



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administration

The Administrator  
Washington, D.C. 20201

APR 5 1995

The Honorable John D. Dingell  
House of Representatives  
Washington, DC 20515

Dear Mr. Dingell:

I am responding to your request as to whether there is any federal requirement that Medicare SFLECT insurers notify their enrollees about the status of their policies prior to the expiration of the current authorization for the demonstration.

There are no provisions in Federal law, regulations or the NAIC Model that require plans to notify enrollees in April or for that matter any time prior to the expiration of the demonstration authority. Even after the demonstration authority expires, plans are required to maintain coverage to all enrollees who continue to hold policies.

Confusion may have arisen on this issue of notification because of a provision in Section 10-N of the NAIC Model. This section outlines the requirements for plans to provide continuation of coverage in the event that the Secretary notifies the states of her determination that SELECT policies should be discontinued because of the failure of the demonstration to be reauthorized or its substantial amendment. This notification to states is at the Secretary's discretion. Given the bipartisan interest in both the House and Senate, we don't anticipate making such a determination in the foreseeable future even in the unlikely event that there is a temporary lapse in the authority for the demonstration.

We are committed to working with Congress to improve the options available to our beneficiaries. As you are aware, the Administration supports a temporary extension of the 15-state demonstration. Such an extension would provide sufficient time to examine what we have learned from the demonstration and to make needed changes to SELECT based on our findings. I look forward to working with you on these issues.

Sincerely,

Bruce C. Vladceck

**Worth Magazine Responses**  
**The White House**

July 8, 1996

**TAXES**

- Q: Would you tax all or a portion of employee benefits to pay for tax reform or to reduce the federal budget deficit? If so, why? If not, why?
- Q: What do you think are the top three most-needed changes to the federal tax law? Why did you pick these three?
- Q: Are you for a middle class tax cut? Why or why not?

**Answer to the above 3 questions on taxes:**

I am committed to tax reforms that are fair to working families, strengthen our economy, and maintain our commitment to a balanced budget.

My balanced budget plan meets these principles because it protects our expansion of the Earned Income Tax Credit for 15 million working families and targets additional tax cuts towards education, childbearing, retirement savings and other key needs of working families. It reforms the tax code to encourage investment in people, not just physical capital.

For example, my balanced budget plan provides a \$1,500 tax credit for the first two years of college, a \$10,000 tuition deduction for education and training throughout one's lifetime, and a \$500 per child tax credit. It also expands IRAs by allowing penalty-free withdrawals for first home purchases, education expenses, major medical expenses, or during long-term unemployment. By doubling the income limits for tax-deductible IRA contributions, 20 million more families will become eligible. In addition, my plan increases the health insurance deduction for the self-employed, simplifies pension rules, and creates a new small business "401(k)" plan to help expand pension coverage to more small business employees.

These targeted tax cuts are paid for by spending cuts and by closing billions in tax loopholes and unnecessary corporate subsidies. That is the right way to cut taxes and reform the tax code. The wrong way is through ill-conceived flat tax proposals or excessive, broad-based tax cuts that either explode the deficit or raise taxes on struggling families.

**Do you think a capital gains tax cut is desirable, given the current deficit? If so, why? If not, why?**

I have always stated that any tax cut must be judged by the following principles: how fair is it, whether it is targeted and efficient, whether it is good for the economy, and what its impact is on the deficit. I will not support proposals that do not meet these standards.

As part of my 1993 Economic Plan, we passed a targeted capital gains tax cut for small and expanding businesses. This tax cut was fair, targeted, good for the economy, and part of a plan to cut the deficit in half. I opposed Republican plans that did not meet these principles. Their plan provided a capital gains tax cut that would not help the economy and was nothing more than a huge, retroactive giveaway.

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In the future, I will consider any tax proposal on the basis of the principles I have laid out.

**Historically, our tax system has been used for social engineering. The system encourages certain economic decisions and behaviors over others. Do you think this is desirable? Why or why not?**

We take it for granted that there are some kinds of corporate investments we want to encourage, such as investments in plant and equipment, and so the tax code encourages them. But I believe it is also appropriate to use our tax system to reward work, provide help for families to save, care for their children, and pay for education, and to ensure productive investments and job creation in our distressed areas.

The tax code currently encourages investment in physical capital. My balanced budget plan contains important tax reforms by recognizing that investment in people and education -- not just physical capital -- deserves tax incentives. For example, my balanced budget makes higher education and training tuition -- up to \$10,000 -- tax deductible. To further encourage investment in education, I recently added a \$1,500 refundable tax credit for tuition in the first two years of college.

My 1993 Economic Plan expanded the Earned Income Tax Credit for 15 million of our most-hard pressed working families, so that our tax system would lift families out of poverty, instead of pushing them into poverty. My plan also provided tax incentives for businesses to locate in some of our most distressed areas:

These changes and proposals are not only good for families, they are good for the economy, and the country.

**What are your plans to strengthen the economy?**

When I took office, the economy was drifting: the deficit was skyrocketing, unemployment was high, and job growth was essentially flat. We put into place an economic plan to reduce the deficit, to invest in our people, and to get this country moving again.

Today, the deficit is half what it was four years ago, the economy has added 10 million new jobs, we have the lowest combined unemployment, inflation, and mortgage rate in 27 years, and the long downward slide in hourly wages has been halted.

We are on the right track, but we must go further. My agenda for growth is based on the following principles: balancing the budget, fair and open trade, increasing economic security, and continuing to invest in education and our children's future.

If we balance the budget, we can keep interest rates down, increase savings, expand companies, start new small businesses, help more families buy homes, and help more parents send their children to college.

We will work to ensure free and fair trade. It has been proven time and again that when American workers are allowed to compete, they win. If other markets are as open to our products as we are to theirs, America's workers will do well.

In the new economy, many workers will have to change jobs more often than in the past. Therefore, we will continue to work to give families the security to know that if they change jobs, they can carry with them access to health care and pensions and education for a lifetime.

More than ever, whether you succeed in the next century is going to be based on what you know. We must expand Head Start, call for performance exams for graduating from each school and work to ensure that every American has access to a world-class education. We will seek to make all students technologically literate and connect every classroom and every library in America to the Internet by the year 2000. And we will continue to expand access to college by pushing for my HOPE Scholarship tax cut; a \$10,000 education tax deduction; penalty-free withdrawals for college tuition from expanded IRAs; expanded work study for one million students; increased Pell Grants to help low- and middle-income students; \$1,000 Honor Scholarships for the top 5% of every high school class; and \$2,600 Skill Grants to help dislocated workers to get the new skills they need.

## **SOCIAL SECURITY**

- Q: Do you think the Social Security system of collecting taxes needs to be revamped? If so, why and how? If not, why?
- Q: Would you recommend raising the age at which individuals become eligible for Social Security? If so, why? If not, why?
- Q: Would you recommend abolishing the cap on earnings where the Social Security tax hits? If so, why? If not, why?
- Q: Would you raise taxes if voters are willing to pay more to keep the Social Security program solvent? If so, why? If not, why?

### **Answer to the above four questions on Social Security:**

We have an obligation to our parents and children to protect Social Security for the future. Under my administration, we have done just that, making Social Security an independent agency, reducing backlogs, and upgrading services. I have opposed, and will continue to oppose, measures to cut Social Security to reduce the deficit or pay for other spending priorities or tax cuts.

While Social Security is on firm financial footing well into the next century, most experts agree that steps will be needed to address its long-term financing and demographic changes. We should address these long-term issues the same way we have done in the past: through serious, bipartisan efforts that put politics aside, and that allow all parties to focus on the steps needed to secure the long-term solvency and maintain the existing broad national support for the Social Security program.

Any discussion of specific proposals should take place in the least political context possible where elements are judged in the context of overall bipartisan plans to secure Social Security. But any overall bipartisan plan will have to ensure that Social Security's financing is sound and prudent, and that Social Security continues to provide the same true security it has provided millions of Americans for decades.

**Q. Would you recommend raising or lowering the age at which individuals become eligible for Medicare? If so, why? If not, why not?**

A: As my budget proposal illustrates, it is not necessary to change the eligibility age of Medicare to address the current financing challenges facing the Medicare Trust Fund or to balance the budget.

It is important to note that making this change would not achieve significant savings for the Medicare program, since seniors between the ages of 65 and 67 tend to be healthier than their older counterparts. Moreover, increasing the age of eligibility may have the unintended effect of significantly increasing the numbers of the uninsured. Because of downsizing and voluntary retirements after age 60, older Americans who haven't reached the Medicare eligibility age of 65 have to try and buy much more expensive individual health insurance policies. Seniors are finding it virtually impossible to find affordable health insurance, particularly if they have a pre-existing condition. For these reasons, I would have concerns about contemplating any increase in the Medicare eligibility age in the absence of broader health reforms that addressed this problem.

**Q. Would you raise taxes if voters are willing to pay more to keep the Medicare program solvent? If so, why? If not, why not?**

A: My balanced budget shows that it is not necessary to raise taxes to address the current financing challenges facing the Medicare trust fund. Through savings and policy changes, my balanced budget would extend the life of the trust fund until 2006.

**Q: What steps would you take to guarantee that each individual could purchase a health insurance plan if they don't get one through their job?**

A: I believe that we must work step by step to ensure that every American has access to affordable health care. The first step we should take is to pass into law the Kassebaum-Kennedy health insurance reform bill now before Congress. This legislation offers previously covered workers who change jobs continued health insurance. I have also proposed to enhance the Kassebaum-Kennedy portability benefit by including in my balanced budget a provision to give assistance with premiums to millions of Americans who have temporarily lost their jobs. We should also provide greater flexibility for states to expand their Medicaid program to working Americans. I have started this by authorizing state Medicaid waivers, and by proposing Medicaid reform legislation to allow states to make these changes without going through a burdensome waiver review process.

**Q. What do you think about Medical Savings Accounts?**

**A:** I am concerned that MSAs would further segment the insurance market between healthy and sick, significantly increasing premiums for people who want to keep their traditional health insurance plans, without containing costs or expanding coverage.

Because of these concerns, I want to know more before we allow open-ended, unconstrained MSAs.

That is why I have proposed working with all interested parties to develop a fair and objective experiment. It is my hope that Republicans and Democrats can agree on the parameters of such a study. I strongly believe, however, that the important insurance and other health reforms included in the Kassebaum-Kennedy bill should not be held hostage to our inability to agree on an appropriate study. We should not forget that this legislation passed the U.S. Senate 100 to 0 without any MSA provision.

**Q. What would you do to make it easier for working families to care for their older and disabled family members?**

**A.** The first step we must take to ensure affordable long-term care is to protect the Medicaid program against proposals to turn it into a block grant. Other than families who finance their long-term care costs themselves, Medicaid is the primary long-term care provider in this nation.

Recognizing this and the other important safety net protections provided by Medicaid, I have steadfastly opposed any proposal to undermine its guarantee of coverage. My balanced budget assures the continued Federal enforcement of national nursing home quality standards and retains protections against the impoverishment of spouses and adult children of nursing home residents. It also contains a proposal for a new respite care program for the families of Medicare beneficiaries suffering from Alzheimer's disease.

While we are protecting and strengthening Medicare and Medicaid and making them more efficient, I believe strongly that we should provide states the flexibility they need to offer more home- and community-based care. My balanced budget gives states additional flexibility to expand home- and community services without Medicaid waivers. It also improves Medicaid and Medicare managed care options by offering the Program of All Inclusive Care for the Elderly (PACE), a new, comprehensive package of acute and long-term care services for elderly beneficiaries eligible for institutional care.

Finally, to make taking care of a parent or a disabled family member more affordable, my balanced budget proposes to allow individuals to withdraw funds from their IRAs without penalty in order to pay for major life expenses, including financially devastating medical expenses or nursing home care for a parent. I am also supporting changes in the tax code that put private, long-term care insurance on a level playing field with traditional health insurance, as long as it meets basic consumer protections. Clearly, the public sector will not be able to provide for all of our nation's long-term care needs. These enhancements to long-term care initiatives will help the private sector be more responsive to the increasing needs of the expanding chronically-ill population.

**Q. Now that the "era of big government is over," how will you help the large baby boom generation accumulate enough to be secure in their retirement?**

**A:** In the last three years we have done a great deal to expand opportunities to save for retirement and to protect pensions. But there is so much more we have to do. Millions of Americans are not saving enough for their retirement. Often they have no choice. They may have a job where there's no retirement plan, have to change jobs, aren't eligible for savings plans, or their employer goes out of business before they become vested.

To help these hard-working Americans, I have proposed The Retirement Savings and Security Act. This comprehensive legislation would help expand pension coverage to the 51 million working Americans who are not now covered by an employer-provided retirement plan. It would help workers take their retirement savings with them and keep saving if they change jobs or lose their job. It also tightens security, so that retirement savings will be there when a worker retires.

First, it would establish a new kind of 401(k) plan for employees of small businesses. Second, it expands IRAs by doubling income eligibility so that 20 million more Americans earning up to \$100,000 a year can take this tax deduction. Third, it increases the portability of pensions to help the more than 5 million workers a year who change jobs and have an employer-provided pension. It means workers in new jobs will not have to wait to start saving in an employer pension plan. And because reform should start at home, we would allow federal workers to save from the first day on the job.

Fourth, we must continue to enhance pension security. We must build on what we have done to help secure pensions through tighter enforcement. Most employers do play by the rules, but we must ensure that no employer can easily skim from their employees' contributions. Our plan cracks down on fraud, requires broader audits, and protects workers like those whose pensions were threatened in the Orange County bankruptcy.

One of the reasons I vetoed the Republican budget was that it gave a green light to corporations to take \$15 billion out of pension plans. We came together in a bipartisan fashion in 1994 to stabilize the pension funds of the country, and we should not turn around and undermine the security of those pensions.

With The Retirement Savings and Security Act, we can help to make retirement something Americans can look forward to, not dread. I hope we can pass all the elements of this plan. This is something we can and should do for America, and we ought to do it now.

**Q. Would you raise or remove the limits on 401(k) plans and individual retirement accounts to encourage individuals to save as much as they can and want? If so, why? If not, why?**

**A.** To better help working families save for their retirement, my balanced budget plan doubles the IRA eligibility limits and indexes for inflation both those limits and the amount that can be contributed tax-deferred. Doubling the income limits will enable another 20 million families to make tax-deductible IRA contributions.

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FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

Number of Pages: 3

Date: 12/9/96

To: Chris Jennings Nancy Ann MIN Mark Miller	From: Debbie Chang
Fax: _____	Fax: <u>202 690-8168</u>
Phone: _____	Phone: : _____

REMARKS: His staff have asked us for some  
paper on the status of the practice expense  
RVV - work. We would like to send  
out the attached paper. May we have  
any comments?

**HEALTH CARE FINANCING ADMINISTRATION**  
 200 Independence Ave., SW  
 Room 341-H, Humphrey Building  
 Washington, DC 20201

## **Update on Resource-Based Practice Expense Relative Value Units**

### **A. Background**

Medicare's physician fee schedule, implemented beginning January 1, 1992, established relative values for three components of each physicians' service: physician work, practice expenses, and malpractice insurance. The sum of these three components represents the relative value for a service; this relative value is used in conjunction with a conversion factor to establish the Medicare fee schedule amount for the service. The relative size of the three components varies for each service, but on average, physician work represents 54 percent of the overall relative value, practice expenses 41 percent and malpractice insurance 5 percent. In FY 1996, out of total physician allowed charges of \$42 billion \$17 billion were for practice expense relative value units.

The Medicare physician fee schedule established relative values for physician work based on physicians' estimates of the resources typically used in delivering each service. Practice expense and malpractice expense relative value units, however, were constructed based on allowed charges under the old reasonable charge system of paying physicians. Relative values for these components thus largely reflect historical values, without a direct and explicit relationship to resources used.

Section 121 of the Social Security Act Amendments of 1994 requires the Secretary of Health and Human Services to develop and implement, effective January 1, 1998, a system of resource-based practice expense relative value units for each physicians' service. The law requires that the methodology recognize the staff, equipment, and supplies used in the provision of medical and surgical services in various settings.

### **B. Framework for Determining Practice Expense Relative Value Units**

Practice expenses include two different categories: direct (or variable) costs and indirect (or overhead) costs. Direct costs cover the specific resource inputs, such as clinical and non-clinical labor, medical supplies, and equipment, that can be identified for a specific service. Indirect costs are overhead costs that do not obviously relate to specific services but that must be allocated across all a practice's services on the basis of some form of general rule. Indirect costs include rent, utilities, office equipment, accounting and legal fees, and similar general expenses. Relative value units can be derived separately for direct costs and for indirect costs and then summed to create practice expense relative value units.

The Health Care Financing Administration (HCFA) will attempt to treat as many physician practice costs as possible as direct costs, explicitly linked to specific services and thus not requiring allocation. HCFA's preliminary estimates are that direct expenses are approximately 60 percent of total practice expenses, versus about 40 percent for indirect expenses.

HCFA has been proceeding by attempting to identify all the specific direct costs for individual services and by developing an allocation method to attribute indirect costs to individual services. As we developed this approach, we sought input from the Physician Payment Review Commission and from researchers expert in relevant methodologies. To collect the data for the development of the practice expense relative value units, HCFA contracted with Abt Associates.

#### Direct expenses

To gather information on direct expenses, Abt convened 15 clinical practice expert panels (CPEPs), each consisting of 8 to 17 physicians. These panels estimated the typical amounts of non-physician labor, including both clinical and non-clinical labor, medical supplies, and medical equipment expended in the provision of MFS services. Because the physician practice incurs different costs in the office and non-office setting, the CPEPs reported these direct service inputs for both settings for services that are performed in both settings. Abt is computing direct cost estimates for each service by applying national standardized prices to the service inputs. HCFA will edit the resulting data for consistency and use scaling techniques to calculate the appropriate set of direct relative value units for all services.

#### Indirect expenses

Allocation of indirect expenses to particular services, a standard problem in accounting, requires some general allocation method or rule that can be used across all services. To obtain information on indirect costs, Abt fielded the Survey of Practice Costs to collect information on aggregate costs and case mix for sampled physician practices. The response rate from a large pilot survey was approximately 25 percent. Such a low response rate called into question the validity and reliability of the results. Statistical experts frequently look for much higher response rates as a safeguard against "response bias," which arises when respondents are not a random portion of the entire sample and which means that the survey results cannot be relied upon to present a true picture of the group from which the sample is drawn. HCFA concluded that the results of this survey could not provide an adequate basis for reliable estimates of practice expense by procedure. Consequently, in September 1996, HCFA instructed Abt to terminate work on the survey.

Data from this survey would have allowed HCFA to attempt to use econometric methods as an option to derive indirect costs estimates for families of codes based on the relationship between aggregate indirect costs and case mix. Clearly, this is no longer an option. We are continuing to assess a number of more standard accounting methods to allocate indirect costs. These methods are based on data that currently exist. Among the options are methods based on two studies recently completed with HCFA funding: one (by Dunn) allocates indirect costs as a function of physician time and the other (by Pope and Burge) uses physician work. Other possible bases for allocation include direct labor costs, direct costs, and various combinations of these variables. No choice among such methods has yet been made.

Reports of these above-mentioned studies, including simulated impacts of resource based relative practice expenses on various specialities, have been widely distributed. These studies should only be viewed as illustrative. HCFA will not use the values generated by these studies. Instead, we will use more recent data and use our own allocation algorithms. In particular, both of these studies simulated impacts based upon the authors' methods for deriving both direct and indirect relative values. HCFA, however, will only use an allocation method for the indirect portion of the practice cost relative value. Since the data HCFA will use for establishing direct relative values is not yet available, simulations available to date should not be relied on as capturing the overall effect of a resource based practice expense relative value scale.

#### **D. Next Major Steps**

Data from the CPEPs on direct inputs and on the costs of these inputs for each code is now being delivered to HCFA. HCFA is proceeding with analysis of these data and with development of options for allocation methods and other procedures. HCFA expects to meet further with representatives of the medical community near the end of the year to present and discuss preliminary relative values under various scenarios. Informal comments from the medical community will be invited at that time.

HCFA plans to publish the Notice of Proposed Rule Making for implementation of resource based relative practice expenses in the spring of 1997; the notice will be followed by a 60 day period for formal public comment. HCFA plans to publish the final regulations (as part of the annual regulation on Medicare physician payment) in November 1997 for implementation on January 1, 1998.

Prepared by HCFA, Nov. 1996

# **Statement of the American College of Surgeons**

to the

**Subcommittee on Health and the Environment**

of the

**House Committee on Commerce**

presented by

**Paul A. Ebert, MD, FACS**

**RE: Medicare Program Issues**

**June 26, 1995**



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# American Medical Association

Physicians dedicated to the health of America



1101 Vermont Avenue, NW  
Washington, DC 20005

## Statement

to the

Subcommittee on Health and Environment  
Committee on Commerce

U.S. House of Representatives

**Re: Medicare Reform**

Presented by Daniel H. Johnson, Jr., MD

June 28, 1995

Division of Legislative Counsel  
202 789-7426

# ASIM TODAY

**Testimony of the  
American Society of Internal Medicine  
to the  
House Commerce Committee  
Subcommittee on Health  
on Medicare Reform**

**August 3, 1995**



**Testimony of the**  
**American Society of Internal Medicine**  
**to the**  
**House Commerce Committee**  
**Subcommittee on Health**  
**on Medicare Reform**  
**August 3, 1995**

Introduction

1 Thirty years ago, the Medicare program was created to ensure that the nation's elderly would not  
2 be denied medical care when they needed it. Today, almost all Americans over 65 feel secure in  
3 the knowledge that health care services will be accessible to them. The American Society of  
4 Internal Medicine, representing the nation's largest medical specialty and the principal providers of  
5 medical care to Medicare beneficiaries, is committed to preserving this contract with older  
6 Americans. However, in the face of changing demographics, burgeoning costs and the need to  
7 restrain overall federal spending, the Medicare program—as well as all those affected by its  
8 policies—is facing an unprecedented challenge.

9  
10 Earlier this year, the trustees for the Hospital Insurance Fund declared that the Part A fund which  
11 finances hospital care will be bankrupt by the year 2002. What few realize is that the fund has  
12 already begun to run a deficit. Bankruptcy is merely the end product of the red ink that is  
13 beginning to accumulate in the system today.

14  
15 As the population of Medicare eligible individuals grows, the ratio of working Americans who  
16 support the program with their payroll taxes to beneficiaries has diminished. Whereas today there  
17 are five working-age persons for each person over 65, by 2030—when today's workers retire and  
18 their children are wage earners—the ratio will be three working-age persons for each American  
19 over 65. Without any policy changes, Medicare SMI (Part B) will grow to more than 7 percent of  
20 the payroll tax base by 2030—up from one percent today. Although beneficiaries overall continue  
21 to have ready access to physicians and other providers, disturbing trends have been identified by  
22 the Physician Payment Review Commission (PPRC) and other organizations tracking the Medicare  
23 program. For example, the PPRC notes in its 1995 report to Congress "those over age 85,  
24 individuals living in poverty areas and the disabled continue to experience access barriers" that  
25 existed prior to the latest round of Medicare reform. The Employee Benefits Research Institute  
26 (EBRI) recently issued data showing that the number of Medicare patients seen each week by  
27 internists has been declining steadily since 1989. At the same time, there has been a significant  
28 increase in internists contracting with managed care plans. In the wake of continuing cuts in  
29 Medicare reimbursement to control program costs, physicians may be entering practice  
30 environments where the degree of involvement with Medicare patients is limited.

31

1 Indeed, savings already enacted in previous budget reconciliation measures that are now being  
2 implemented will reduce payment levels to physicians over the next seven years by 17 percent,  
3 even before the impact of inflation is taken into account. Under one of the savings options  
4 proposed by a subgroup of the House Budget Committee, the reductions in payment levels for  
5 physician services will increase to 31 percent over the next seven years. If the debate beginning  
6 now in Congress is about making sure the elderly have access to appropriate, high quality health  
7 care into the next century, continued reductions of this type will only undermine this promise and  
8 create a Medicare program that guarantees access in name only.

9  
10 If no action is taken, the hospital side of Medicare will go broke in less than a decade, the  
11 supplemental medical insurance portion of Medicare will consume increasing amounts of the  
12 federal budget and beneficiaries may face increasing difficulty in obtaining needed health care.  
13 This is clearly not a viable option.

14  
15 Policymakers could continue with the historical approach to attempting to reign in Medicare's  
16 costs—enacting cuts in provider payments and imposing increasing regulatory rules on the  
17 program as part of massive year-end budget reconciliation measures. This, of course, does not  
18 address the underlying reasons for increasing costs under the program and will only serve to  
19 exacerbate many of the growing problems in Medicare.

20  
21 The third option is to reform Medicare by correcting growing inequities in the current payment  
22 system that discourage the delivery of primary care, by placing Medicare's financing on a sound  
23 basis and by introducing the kind of marketplace incentives that have enjoyed success in the  
24 private sector in holding down the growth of health care costs. ASIM strongly believes that this is  
25 the only option that Congress should consider.

26  
27 ASIM recognizes the urgent need for reforming the Medicare program and restraining growth in  
28 spending under other federal health care programs. However, intermists also believe that  
29 significant changes in these programs *ideally* should be made in the context of other health  
30 system reforms. Medical liability reform, insurance market reform, measures to broaden and  
31 protect choice of plan and physician, and steps to ensure due process for patients and providers  
32 in health plan operations and clinical decisions are important system-wide reforms that will foster  
33 an environment in which changes in Medicare will have a positive impact.

34  
35 Nevertheless, the following recommendations comprise ASIM's response to policymakers' calls for  
36 proposals to address the need for fundamental changes in the Medicare program so that it may  
37 continue to be a reliable source of medical care for the nation's elderly well into the new century.  
38 The recommendations propose both immediate and longer-term reforms in the following areas:

- 39  
40 1. Reforms that can be enacted today in the Medicare fee schedule to alleviate the  
41 adverse impact on primary care and other nonsurgical services of current and  
42 proposed reductions in payments for physicians' services.
- 43  
44 2. Immediate changes to be made in Medicare financing and the existing Medicare  
45 risk contracting program.
- 46  
47 3. Longer term reforms to expand beneficiaries' choice of insurance options through  
48 enactment of a defined federal contribution—or voucher—program.
- 49

## 1 Reforming the Medicare Fee Schedule

2  
3 ASIM believes that any attempt to reform Medicare that does not address existing inequities in the  
4 Medicare fee schedule that distort the intent of the resource based relative value scale—and that  
5 also create strong financial disincentives for physicians to enter and remain in primary care—will  
6 only lead to further imbalance within the system. These inequities stem from a number of  
7 decisions made by past Congresses in enacting and modifying the original 1989 Medicare  
8 physician payment reform plan.

9  
10 Under Medicare law, there are three separate target rates of spending growth – called volume  
11 performance standards (VPS) – for surgical procedures, primary care services, and all other  
12 nonsurgical services. This has resulted in three separate conversion factors—the dollar multiplier  
13 which translates Medicare's resource based relative value scale (RBRVS) into fees—for surgical  
14 procedures, primary care services, and other nonsurgery. Prior to 1993, there were only two  
15 separate VPSs and conversion factors, one for surgical procedures and one for nonsurgery.

16  
17 In OBRA 93, Congress added a VPS category for primary care services—office, nursing home,  
18 home, and emergency room visits—in addition to the other two categories. Creation of a separate  
19 primary care category was intended to moderate any adverse impact on primary care services of  
20 other changes made by OBRA 93 lowering payments for physician services. However, all  
21 services paid under the Medicare fee schedule—including primary care services—will begin  
22 experiencing payment reductions in the next two years and beyond because OBRA 93 doubled  
23 from two to four percent the required "performance standard reduction" that is subtracted from the  
24 five year historical rate of increase for physician services for the purposes of calculating the VPSs.

25  
26 ASIM's concern about the impact of Medicare cuts is exacerbated by the fact that the current  
27 formula for determining Medicare fee schedule updates, as modified by OBRA 93, will have a  
28 greater adverse impact on primary care and other nonsurgical services than on surgical  
29 procedures. **These are the facts:**

- 30  
31 ● Under current law, the amount that Medicare pays for primary care services will  
32 automatically be cut by 2.2 percent in 1996, unless Congress decides otherwise.  
33 Primary care is the only category of Medicare expenditures that will be cut next year  
34 even before additional savings are mandated.
- 35  
36 ● Under current law, all other physician services are expected to join primary care in  
37 experiencing annual fee cuts beginning in 1997 and continuing every year, according  
38 to the CBO and Physician Payment Review Commission. Medicare payments for  
39 primary care will be cut by 17 percent over the next seven years.
- 40  
41 ● Additional proposed savings, such as the three percent reduction in updates  
42 proposed by the House Budget Committee's Health Care Working Group, will cut  
43 Medicare fees for primary care services by more than 31 percent over the next seven  
44 years, even without considering the impact of inflation. Other proposals would cut  
45 fees even more.
- 46  
47 ● Under previously enacted and proposed cuts, Medicare fees nationwide for a  
48 typical 15 minute office visit will drop from about \$35.00 in 1995 to \$34.00 in 1996,  
49 \$27.00 in the year 2000, and less than \$24.00 in 2002.

1 ● Because of the cuts, Medicare fees for primary care services will not cover  
 2 overhead. According to national surveys, internists in 1992 incurred annual overhead  
 3 costs of \$172,900, or \$3458 weekly (assuming 50 work weeks). Internists' offices are  
 4 open an average of 27.3 hours per week. This means that the overhead costs are \$126  
 5 per hour for each hour the office is open. In 1996, internists will barely break even under  
 6 Medicare's fees for a 15 minute office visit (\$136 in revenue per hour). By 2000, the  
 7 revenue from office visits—\$108 per hour—would not cover overhead even assuming  
 8 no increase in overhead costs from the 1992 costs.

9  
 10 ● Many internists report that they will have no choice but to limit the number of  
 11 Medicare patients in their practices, to curtail services, or to take other steps to  
 12 reduce reliance on Medicare if the current and proposed cuts are allowed to go into  
 13 effect. A recent ASIM survey of a typical group of several hundred internists nationwide  
 14 asked how they would respond to reductions of "up to 20 percent" in Medicare fees.  
 15 Since the proposed reductions would be much greater, their responses *underestimate* the  
 16 probable adverse impact on patient care. Only 25 percent said they would "make no  
 17 change" in their practice. Forty-six percent would limit the number of new Medicare  
 18 patients; 8 percent would discontinue taking care of current Medicare patients; 10  
 19 percent said they would change their career; 31 percent would change their practices  
 20 so that they are no longer dependent on Medicare revenues; 38 percent would  
 21 reduce services to beneficiaries; and 21 percent would plan an earlier retirement.

22  
 23 The following chart illustrates what will happen to payments for three different types of primary  
 24 care services under cuts already contained in the law and under proposed reductions. The  
 25 "current law" column reflects established 1995 fees, the 1996 default update of -2.2 percent for  
 26 primary care services, and the PPRC's estimates of the conversion factor reductions for 1997-2002  
 27 based on savings mandated by OBRA 93.

28  
 29 The "proposed 3 percent reduction" column assumes that Congress allows the -2.2 percent  
 30 default update for primary care services to go into effect in 1996 and reduces the conversion  
 31 factors for all services by 3 percent per year beginning in 1997. These figures assume a  
 32 reduction in future updates of 3 percent per year as proposed by a subgroup of the House  
 33 Budget Committee and do not include other proposals in the subgroup's document that would  
 34 save another \$16 billion in physician services paid under the Medicare fee schedule. Even if  
 35 Congress does not enact the 3 percent conversion factor update reduction proposed by the  
 36 subgroup, other savings proposals that would result in a comparable reduction in Medicare fee  
 37 schedule payments would have the same impact as illustrated below.

38  
 39 Because the estimates in both columns do not take into account the impact of inflation, they  
 40 *understate* the extent of the reductions in payments for primary care services.

**Office Visit (level 3)**

	1995	1996	2000	2002	Percent Change
Current Law	\$34.92	\$34.16	\$30.50	\$28.93	-17.2
3% CF Reduction	\$34.92	\$34.16	\$26.90	\$23.97	-31.4

**Nursing Home Visit (level 2)**

	1995	1996	2000	2002	Percent Change
Current Law	\$48.39	\$47.32	\$42.25	\$40.09	-17.2
3% CF Reduction	\$48.39	\$47.32	\$37.27	\$33.21	-31.4

**Home Visit (level 2)**

	1995	1996	2000	2002	Percent Change
Current Law	\$61.48	\$60.13	\$53.69	\$50.94	-17.1
3% CF Reduction	\$61.48	\$60.13	\$47.35	\$42.20	-31.4

To correct the flaws that will otherwise worsen the impact on primary care and other nonsurgical services, ASIM strongly supports the following recommendations in the Physician Payment Review Commission's 1995 Report to Congress:

**A single volume performance standard and update for all categories of services should be adopted. If separate standards and updates by categories of services are retained, they should be based on the recent trend in volume and intensity growth for each category as called for by the Omnibus Reconciliation Act of 1990, and differential updates should be in effect for one year only.**

**The current formula—five year historical trends minus a four percent performance standard reduction—should be replaced by per capita GDP, plus an additional factor of one or two percent.**

There are several reasons why these changes in the law should be enacted:

**First, mandating that the VPSs be based on GDP plus two percentage points is needed to reduce the adverse impact on access and quality that will otherwise occur from fee**

1 reductions. Because OBRA 93 doubled the performance standard reduction factor, it will be  
2 impossible to keep spending within the VPS targets. The PPRC notes that "the problem is that  
3 this [four percent performance standard] reduction is now permanently embedded within the  
4 default formula and applies even as the 1991 to 1993 growth rate is the lowest two-year growth  
5 rate since 1985. In effect, the formula demands that however well physicians did in meeting the  
6 previous year's standard, they must reduce volume by an additional 4 percentage points each  
7 year or pay a penalty in reduced fees. Clearly, it is impractical to expect that physicians will  
8 continue to achieve such savings year after year." The current formula sets in motion a steady  
9 decline in Medicare fees beginning in 1996 for primary care services, and in 1997 for all other  
10 services, that will continue into the foreseeable future. Because overhead costs cannot be  
11 reduced to offset these cuts, ASIM estimates that net Medicare payments will be reduced over 60  
12 percent. The result will be a serious reduction in access to physician services and especially,  
13 access to primary care. Additional savings that Congress may mandate could have devastating  
14 consequences for access. A formula of GDP plus two would reduce or eliminate the fee  
15 reductions and the need to constantly reduce the number of services provided to patients. To  
16 maintain budget neutrality, a change to the GDP plus two formula could be offset by a one time  
17 reduction in the conversion factors, provided that this is done in a way that reduces the gap  
18 between the surgical conversion factor and the other two categories.

19  
20 **Second, the current method for determining the fee updates and VPSs will magnify and**  
21 **accelerate the access problems resulting from budget cuts.** The elderly depend on primary  
22 care physicians for their access into the Medicare system. Primary care is therefore the first place  
23 where access problems will begin to become evident. As noted earlier, access barriers continue  
24 to exist for the very old, the disabled and the poor. The Physician Payment Review Commission  
25 staff estimates that under the current formula, the 1997 conversion factor for surgical procedures  
26 will be 26.7 percent higher than for primary care services and 29 percent higher than for other  
27 nonsurgical services. Because the conversion factors for primary care and other nonsurgical  
28 services start out so much lower than for surgical procedures, any additional cuts in the  
29 conversion factors will disproportionately hurt primary care physicians and other medical  
30 specialists. It is irrational to have in place a policy that is inherently disadvantageous to primary  
31 care when access to primary care is at the greatest risk of being reduced.

32  
33 **Third, the method for determining the VPSs and fee updates is inherently contradictory to the**  
34 **intent of the resource based relative value scale (RBRVS).** The RBRVS was intended to pay  
35 physicians the same amount for services that involve equal physician work. But the current policy  
36 of different conversion factors will result in surgeons being paid 25-30 percent more for their  
37 surgical procedures than primary care physicians are paid for a non-surgical service requiring the  
38 same amount of time, mental effort and judgment, technical skill and stress. It is precisely the  
39 kind of contradictory federal policy exemplified by the VPS method that has led to widespread  
40 distrust and dissatisfaction with way that Washington does things.

41  
42 **Fourth, the current method encourages inefficiency, since it penalizes many physicians for**  
43 **changes in practice patterns that may reduce Medicare expenditures while rewarding others**  
44 **for reductions in volume over which they have no direct control.** Some have argued that the  
45 policy of maintaining separate VPSs and conversion factors should be supported because it  
46 "rewards" surgeons for reducing volume by more than other physicians. The evidence suggests,  
47 however, that the reduction in surgical volume is due principally to changes in practice patterns,  
48 such as the substitution of less expensive forms of treatment by Internists for conditions that used

45  
46 Last December, a report on entitlement reform options was issued by staff from the Bipartisan  
47 Commission on Entitlement and Tax Reform (hereinafter referred to as the Commission). That  
48 report identified a number of measures that could be enacted in the existing Medicare program to  
49 stem the imbalance in funding. These improvements can be made with or without enactment of

1 other long term reforms, such as a voucher program. Among those improvements ASIM supports  
2 are:  
3

4 1. Increasing the eligibility age for Medicare to align it with eligibility for Social  
5 Security. By early in the next century, the eligibility age for Social Security will be  
6 67. It would make sense, both financially and administratively, to couple the  
7 eligibility age for Social Security with that for Medicare. However, such a change  
8 must come in concert with insurance market reforms and other measures to assist  
9 those elderly under 67 with chronic, but not disabling, illnesses in maintaining  
10 insurance coverage.

11  
12 2. increasing the amount contributed by upper income beneficiaries to financing  
13 the Medicare system. The Commission staff proposed reducing the Part B  
14 premium subsidy and creating a new Part A premium indexed according to growth  
15 in program costs. ASIM believes this premium should instead be indexed to  
16 income. This would avoid imposing an excessive burden on those with modest  
17 means while concomitantly calling for appropriate contributions from those with  
18 greater ability to finance their health care.

19  
20 3. applying the Part B coinsurance to home health services. Current law requires  
21 no cost sharing by beneficiaries for these services. Home health care has been  
22 among the fastest growing parts of the Medicare budget and cost sharing has  
23 been demonstrated effective in stemming overutilization of services.

24  
25 4. including in taxable income the value of health insurance benefits beyond a set  
26 value of insurance premium. Today, employers and workers benefit from a system  
27 that gives preferential tax treatment to high cost health plans. Placing a limit on  
28 the tax deductibility of such health insurance will promote the purchase of cost-  
29 effective but moderately priced health plans and would bring in significant revenue  
30 into the health care financing system.

31  
32 5. limiting disproportionate hospital share (DSH) payments only to those facilities  
33 that, in fact, care for a disproportionate share of Medicare patients. The  
34 Commission staff report cited studies showing that DSH payments, intended to  
35 compensate hospitals for services provided to low income individuals, have been  
36 used by some states for purposes beyond its original intent. Without harming  
37 those hospitals truly in need of these payments, the formula should be changed—  
38 e.g. elimination of DSH payments for hospitals whose disproportionate share index  
39 is below the 80th percentile—to avoid inappropriate uses of federal payments.  
40

41 In accord with ASIM's longstanding policy that Medicare trust fund reserves should be augmented  
42 through a combination of expenditure reductions, program efficiencies and revenue increases,  
43 ASIM also supports:  
44

45 6. increasing federal excise taxes on alcohol and tobacco if the revenues from  
46 changes identified above prove inadequate to finance an appropriate level of  
47 benefits. Not only would these additional revenues help to support the program  
48 but they would discourage certain behaviors that result in increased public and  
49 personal health costs.

1 Historically, Medicare has served as a major source of financing for training of this nation's  
 2 doctors. However, changes have been proposed in Medicare's funding of graduate medical  
 3 education (GME) as another avenue for achieving significant savings in the program's budget.  
 4 One proposal offered by the Health Care Working Group of the House Budget Committee would  
 5 cut direct and indirect GME spending by \$27.24 billion over seven years.  
 6

7 ASIM believes it is time to rethink Medicare funding of graduate medical education, not simply as  
 8 a device to reduce federal spending, but in order to respond to the changing health care delivery  
 9 environment and to ensure that all components of the health care system that benefit from highly  
 10 trained physicians contribute to the cost of their education. To those ends, ASIM supports:  
 11

12 7. creation of a national all-payer funding pool for GME. All payers and health  
 13 plans should contribute a percentage of their premiums to a financing pool for  
 14 graduate medical education. With managed care plans and other health delivery  
 15 organizations seeking qualified, well-trained physicians for their networks, they, as  
 16 well as all payers interested in providing the best care possible for their insureds,  
 17 have a stake in the education of the physicians that will contract with their plans.  
 18 Until now, no one has asked these health plans and insurers to help support the  
 19 cost of training this nation's physicians. However, given Medicare's financial  
 20 condition, the federal government can no longer be viewed as a major source of  
 21 funding for the future supply of doctors.  
 22

23 8. creation of a private sector physician workforce planning initiative. The  
 24 American Medical Association has proposed that a taskforce be established with  
 25 participation of both public and private sectors to offer recommendations to  
 26 Congress about the physician workforce supply and the future of GME. If the all-  
 27 payer GME pool is established, such a task force will be necessary to advise how  
 28 the funds in the all-payer pool would be distributed.  
 29

30 9. increasing the direct GME weighting factor for general internal medicine and  
 31 other primary care residency positions while decreasing the weighting factor for  
 32 others. Currently, direct medical education payments are based on hospital-  
 33 specific, per resident costs multiplied by the number of residents. Proposals have  
 34 been offered in past Congresses to reimburse hospitals more for primary care  
 35 residents than for specialty residents in order to encourage training of more  
 36 primary care physicians. The need for more primary care physicians has grown  
 37 with the increase in the elderly population as well as with the desire of health plans  
 38 for physicians to manage the care of their enrollees. Alterations in the financing of  
 39 medical education will encourage changes in training programs to meet those  
 40 needs.  
 41

42 10. decreasing the number of funded residency positions to 110 percent of U. S.  
 43 medical school graduates. The Physician Payment Review Commission has  
 44 recommended that the number of funded residency positions in the United States  
 45 be reduced in order to respond to the fact that the country is facing, in general, an  
 46 excess of physicians. By taking this action, the U. S. would cut the oversupply of  
 47 physicians while at the same time—if the other steps are taken—increase the  
 48 proportion of primary care physicians relative to the population.  
 49

## 1 Instilling Market-based Incentives in the Medicare Program

2  
3 The current Medicare program includes an optional program intended to use competition among  
4 health plans as a means to moderate costs. The Medicare risk contracting program—in which  
5 Medicare contracts with health plans and pays them a capitated payment based on less than 95%  
6 of the adjusted actual per capita costs of caring for Medicare patients—was intended to encourage  
7 health plans to control utilization of services and, subsequently, costs. Because of flaws in the  
8 formula for paying risk contracting plans and because healthier beneficiaries are more likely to  
9 enroll in these health plans than other beneficiaries, the risk contracting program has not been as  
10 successful at reducing Medicare spending as originally anticipated.

11  
12 Again, steps can be taken to improve this existing mechanism designed to enhance market  
13 competition until more substantial reforms are implemented. These include:

14  
15 1. changing the adjusted average per capita cost (AAPCC) formula used to pay  
16 health plans. The current AAPCC is based on historical, fee-for-service costs in an  
17 area. This has resulted in overgenerous payments to health plans in high cost  
18 areas and modest payments to health plans in regions where health care costs  
19 have been kept relatively low. Changes in the AAPCC should reward cost effective  
20 health plans in areas with historically low utilization rates instead of penalizing  
21 such plans with less generous AAPCC payments.

22  
23 2. applying risk adjustments—such as severity of illness—in setting payments to risk  
24 contracting plans. This change should be coupled with other reforms in the  
25 AAPCC to avoid driving away from the program managed care plans that might  
26 attract more seriously ill patients and to make regional plan payments more  
27 equitable.

28  
29 3. broadening managed care choices for beneficiaries to include HMOs with point-  
30 of-service and preferred provider organizations (PPOs), instead of limiting  
31 participation only to health plans that require beneficiaries to obtain services from  
32 contracted physicians and other providers. Under the current risk contracting  
33 program, beneficiaries have a limited range of health plans from which to choose  
34 and are precluded from taking advantage of the numerous managed care products  
35 that have arisen in recent years in the private market.

36  
37 4. requiring that beneficiaries be provided comparative information concerning all  
38 Medicare risk contracting plans that are available to them. In order for  
39 beneficiaries to make fully informed choices about their health plan, they should be  
40 provided sufficient data that will enable them to compare these plans on costs,  
41 physicians and other providers, quality and benefits.

42  
43 5. giving beneficiaries one opportunity per enrollment year to disenroll from a plan  
44 within 60 days of enrollment. Once a beneficiary has been in a plan over 60 days,  
45 he or she should be required to wait until the next open enrollment period. Under  
46 current law, beneficiaries may disenroll from a health plan with only a 30 days  
47 notice. This makes it difficult for many risk contracting plans to anticipate costs for  
48 a health plan year. It is also contrary to most enrollment policies effective in the  
49 private sector which call for enrollment or disenrollment during a particular "open

1 season". Asking beneficiaries to stay with a plan until the next open season once  
2 they have been in a plan for two months would offer additional stability to a risk  
3 contracting plan without limiting too severely beneficiaries' ability to change their  
4 minds about managed care. Such a requirement would make Medicare more  
5 consistent with the private sector in which workers are required to make an annual  
6 selection of a health plan and to stay with that plan for an entire year. Limiting the  
7 disenrollment opportunity to one per year would also prevent cases in which  
8 people jump from plan to plan every so often prior to the 60 day deadline.  
9 Medicare patients should accept the same degree of responsibility in choosing a  
10 health plan that is expected from those under 65.

11  
12 6. mandating reasonable, non-punitive increases in premiums and other cost  
13 sharing for beneficiaries who choose to remain with the traditional fee-for-service  
14 Medicare program. With improvements in the risk contracting program, it is  
15 reasonable to expect that those who choose to remain with the higher cost fee-for-  
16 service side of Medicare should bear a portion of those higher expenditures.

17  
18 The current risk contracting program would be repealed upon enactment of a voucher program as  
19 described below.

#### 20 21 Medicare Vouchers

22  
23 Making changes in the existing fee-for-service Medicare program and improvements in the current  
24 risk contract program will help to stabilize the program for the short term. However, to achieve a  
25 system that relies on competition to control costs and broaden beneficiary choices, that instills  
26 individual responsibility for the appropriate use of scarce medical resources and that assures the  
27 long term survival of Medicare, major restructuring of the program will be required. One way to  
28 do this is for the government to offer beneficiaries the opportunity to take a defined government  
29 contribution—or voucher—and purchase private insurance coverage with those funds.

30  
31 There are a number of issues that must be addressed for any voucher plan to be successfully  
32 implemented. ASIM supports creation of a voucher system and believes that the following  
33 elements are necessary to any voucher program designed for Medicare to ensure that  
34 beneficiaries have access to the widest range of cost-effective, high quality health plans,  
35 physicians and providers.

36  
37 1. Medicare beneficiaries should be given the option of staying in the current  
38 Medicare program or using a voucher to buy any private health plan that meets  
39 certain conditions of participation.

40  
41 If a plan purchased with a voucher becomes insolvent, or ceases operation in a  
42 beneficiary's area, beneficiaries should be able to enroll in another plan. When the  
43 annual enrollment period occurs, beneficiaries should be able to return to the  
44 traditional Medicare program at that time.

45  
46 Transition to a voucher program should be done gradually to account for the fact that some areas  
47 of the country may not have the degree of managed care penetration necessary to make  
48 competition among health plans work. Retaining traditional Medicare would provide reassurance

1 to beneficiaries while serving as a spur to voucher plans to make their products attractive enough  
2 to encourage enrollment by Medicare recipients.

3  
4 2. Under a voucher program, beneficiaries should have access to a variety of  
5 plans ranging from indemnity models to staff model HMOs. All voucher plans that  
6 restrict enrollees to the use of network providers should be required to offer at an  
7 actuarially-determined cost an optional rider that would provide point-of-service  
8 access to non-network physicians for those enrollees. Enrollees should be able  
9 to select from among a network plan's panel of physicians an Internal medicine  
10 subspecialist as their primary care physician and plans should be prohibited from  
11 discriminating against physicians in their selection processes based on a  
12 physician's patient population.

13  
14 Under the present Medicare system, beneficiaries are entitled to receive all covered benefits from  
15 any provider of their choice. A voucher system could undermine this basic premise of the  
16 program. For example, depending on the amount of the voucher and other rules governing the  
17 voucher program, beneficiaries could find their choice of health plan in reality to be quite limited.  
18 Furthermore, if the voucher is inadequately funded, some beneficiaries may be compelled to  
19 select a plan that limits the physicians and providers they may see for services. Adequate choice  
20 of physician and health plan can be promoted by offering beneficiaries a wide menu of plans and  
21 by establishing the federal contribution at a level that does not force patients to choose the  
22 cheapest plan available, as discussed below. By requiring voucher plans that use a network of  
23 physicians to offer enrollees the opportunity to buy a point-of-service rider, enrollees who want the  
24 flexibility to go outside the network will be able to select this option while those beneficiaries who  
25 wish to choose a closed-panel HMO may do so. In addition, a POS rider requirement for all  
26 health plans with restricted provider networks might ameliorate adverse risk selection arising from  
27 the tendency of very ill beneficiaries in an area to gravitate toward traditional Medicare and/or one  
28 plan with point-of-service.

29  
30 3. Beneficiaries should have the option of using their government contribution--  
31 e.g. the voucher--to establish a Medical Savings Account (MSA) rather than to  
32 purchase coverage through a health plan. The MSA would:

33  
34 a) be coupled with a catastrophic health insurance policy purchased through a  
35 purchasing group to help preserve community rating;

36  
37 b) be comprised of a fund from which a beneficiary could pay deductible medical  
38 expenses and would be coupled with purchase of catastrophic health insurance to  
39 cover expenses that, in the aggregate, exceed the catastrophic insurance  
40 deductible;

41  
42 c) permit accumulation of unspent balances within the fund;

43  
44 d) allow state and federally tax exempt distribution of funds only for medical  
45 expenses, health insurance premiums and/or long term care.

46  
47 Since 1987, ASIM has supported the concept of medical savings accounts and the idea of  
48 integrating medical savings accounts into an overall health system in which people could choose  
49 among a variety of health plans, including medical savings accounts. These accounts are useful

1 as part of a continuum of health care coverage options, particularly for their impact in enhancing  
2 consumers' awareness of the costs of health care.

3  
4 ASIM feels strongly, however, that MSAs should not be used as the sole source of health care  
5 coverage but should be established in concert with a catastrophic health insurance policy.  
6 Furthermore, ASIM agrees with the concerns of some MSA critics that these accounts would  
7 adversely affect community rating of insurance and diminish the potential for widening insurance  
8 coverage. Ways to ameliorate these effects include ensuring that money in an MSA be used only  
9 for health care, including long term care, and making MSAs available for purchase only through  
10 purchasing groups to address problems with community rating.

11  
12 ASIM acknowledges that MSAs appear to run counter to the trend in the health care system  
13 toward managed care. On the other hand, a spokesman for the American Academy of Actuaries  
14 Workgroup on MSAs predicted that managed care plans may respond "creatively" to these  
15 savings accounts by offering managed care products compatible with MSAs. Because MSAs  
16 appeal to so many patients and physicians, ASIM believes efforts should be made to include them  
17 in the menu of coverage options available to beneficiaries. To make medical savings accounts a  
18 reality under the Medicare program, however, will require many more provisions than the outline  
19 provided above. To implement MSAs, answers will be needed to questions such as: how will the  
20 government ensure that the funds in an MSA are, in fact, used for health care purposes?; will  
21 beneficiaries be able to contribute their own money to MSAs and, if so, will there have to be  
22 separate accounts established for private funds and the federal contribution?; can the savings  
23 instrument into which the government contribution is placed be protected against adverse market  
24 downturns so that beneficiaries do not lose their medical coverage?; should copayments be  
25 required as part of the catastrophic coverage?

26  
27 4. Voucher plans should be required to accept all applicants during an open  
28 enrollment period to minimize adverse risk selection. Beneficiaries should be  
29 allowed one opportunity per enrollment year to disenroll from a plan within 60 days  
30 of enrollment. Once a beneficiary has been in a plan over 60 days, he or she  
31 should be required to wait until the next open enrollment period. Beneficiaries  
32 should be explicitly informed of this requirement by the health plan and should be  
33 required to sign a written acknowledgement of the conditions of enrollment.

34  
35 A reinsurance mechanism should be available to those plans subject to adverse  
36 risk selection or to a sudden influx of voucher enrollees whose previous plan has  
37 gone bankrupt.

38  
39 Another set of problems related to choice of physician and plan has to do with the response of  
40 health plans to those beneficiaries holding vouchers. To avoid circumstances in which health  
41 plans sought to avoid covering the very ill, all plans should be required to enroll any beneficiary  
42 with a voucher who seeks entrance into the plan. On the other hand, mandated acceptance and  
43 the ability of beneficiaries—under current Medicare risk contract rules—to enroll and disenroll  
44 outside of any prescribed enrollment period leaves plans vulnerable to unanticipated costs. In  
45 such a scenario, beneficiaries' right to choice of plan/physician conflicts with health plans' needs  
46 to maintain their cost and utilization control. The Congressional Budget Office has suggested that  
47 an annual enrollment period with a point-of-service policy "would permit Medicare enrollees to go  
48 to providers outside [a managed care plan's] panel when they wanted to and yet it need not  
49 increase benefit costs for either the [the plan] or Medicare." To avoid circumstances in which

1 beneficiaries enroll in and disenroll from plans multiple times using the 60 day window, there  
2 should only be one opportunity during an enrollment year to disenroll from a plan within two  
3 months, after which the beneficiary would have to wait for the next open enrollment period.  
4 For such changes to work, beneficiaries must be given enough information at the outset to  
5 understand that, in signing up for a managed care plan, they must remain with that plan until the  
6 next open enrollment period once they have been in a plan over two months. This puts the  
7 burden of education on the managed care plan and the decision in the hands of the beneficiary.  
8 In addition, such an approach would make managed care more palatable to both beneficiaries  
9 and physicians.

10  
11 5. The defined contribution—or voucher—should be set at a level that would  
12 produce incentives for beneficiaries to consider cost in choosing a health plan  
13 without forcing them into the cheapest plans that are most restrictive of choice of  
14 physician. The voucher should not be set at the cost of the lowest priced plan in  
15 a region.

16  
17 The voucher amount should be adjusted according to age, sex, disability status,  
18 institutional status, and Medicaid-buy in status and applied by region. Once the  
19 regionally adjusted voucher amount was established, HHS or HCFA would accept  
20 applications from health plans to participate in the voucher program.

21  
22 If the voucher is set too high it will have little impact on controlling Medicare costs. Set too low  
23 and beneficiaries choosing the voucher option may find their choice of plan and, ultimately choice  
24 of physician, quite limited. In addition, for a segment of the Medicare population, a voucher will  
25 not cover what a health plan would spend on treating them. This would seem to call for some  
26 type of adjustment in the value of the voucher through mechanisms that are reasonably simple  
27 and inexpensive to administer. Otherwise, health plans might attempt to discourage certain  
28 beneficiaries from selecting that plan by adopting discriminatory policies or marketing strategies.

29  
30 A voucher set at some national average would fail to reflect the appropriate regional differences in  
31 costs of health care delivery. Setting a regional voucher amount is a more accurate way for the  
32 voucher to reflect local health care costs, would be less likely to drive people into restrictive  
33 health plans and would ensure that there would be at least one plan in a region that could serve  
34 Medicare beneficiaries for the price of the voucher. Any process used to set the voucher amount  
35 in which plans submit their premiums to the government and the government then sets the  
36 voucher on some portion of those premiums must ensure that the resulting voucher is not so low  
37 as to make it worthless to most beneficiaries.

38  
39 6. The voucher should be updated on a regular basis to keep pace with the costs  
40 of providing services to beneficiaries. In the event that spending under the  
41 voucher program exceeds estimated savings goals or targets, the voucher should  
42 not be subject to arbitrary caps. Mechanisms to keep spending within designated  
43 limits or to recoup excess expenditures, such as a "look back sequester", should  
44 be rejected. Instead, an independent board or commission should be established  
45 that would involve all participants in the health care system in devising a response  
46 to cost control that would not focus solely on cuts to providers and increased  
47 costs to beneficiaries. If spending is greater than projected due to development of  
48 valuable new technologies or increased patient utilization of services deemed  
49 medically necessary, there should be a commitment to increasing the amount of

1 funds devoted to the voucher program in order to ensure vouchers retain sufficient  
2 purchasing power and to assure appropriate medical outcomes.  
3

4 The way in which the voucher is updated will determine to a large extent how much purchasing  
5 power the voucher continues to give beneficiaries. Given too great an increase and the voucher  
6 will be ineffective in controlling health costs. Given too little, and the voucher may drive some  
7 beneficiaries into lower quality, more restrictive health plans. There is also always a risk that the  
8 voucher update could fall victim to budget politics and be "frozen" or "capped" at some point to  
9 meet deficit reduction targets.

10  
11 If spending under a voucher program is higher than anticipated because valuable new  
12 technologies or treatments have become available and patients have sought to take advantage of  
13 these advances in medicine, it does not make sense to penalize physicians by cutting their  
14 payments when costs increase for legitimate reasons. Furthermore, if beneficiaries do not  
15 participate in the voucher program in numbers sufficient to keep costs down, physicians should  
16 not be held financially responsible for beneficiaries' independent decisions. In addition, across-  
17 the-board cuts in physician and provider payments do not target those areas where health care  
18 costs have inappropriately increased and penalize caregivers who may in fact have kept their  
19 costs down. Arbitrary reductions in payments will serve only to perpetuate inequities in the  
20 Medicare payment system and compel physicians to limit their exposure to Medicare patients.  
21

22 Finally, a cap on spending for the voucher implies a lack of confidence in the ability of the market  
23 to control the cost of health plan premiums and may have the unintended consequence of  
24 becoming a "floor" rather than a ceiling. If health plans know that the government's contribution  
25 will be capped at a certain percentage rate of growth, this may serve as an incentive to those  
26 plans whose rates of growth are lower than that percentage to allow their premiums to rise to  
27 meet the government's growth rate.  
28

29 In the event federal health program costs remain uncontrollable, some entity -- such as a  
30 commission or board -- should be established separate from any government financing office to  
31 involve all parties in the health care system in devising a response to cost control that would not  
32 focus solely on cuts to providers and increased costs to beneficiaries. If beneficiaries are to be  
33 assured of getting all the necessary care they need when they need it, the voucher amount  
34 should keep pace with the costs of providing services. If the value of the voucher is allowed to  
35 erode over time, beneficiaries may lose access to many high quality health plans offering  
36 comprehensive services or they may be forced to pay increasing amounts out-of-pocket to  
37 maintain a certain level of service. This would be especially detrimental for those beneficiaries of  
38 low and moderate-income who may be unable to bear an increasing financial burden. If the  
39 market is unable to deliver health care to patients within a predetermined cap, this should not be  
40 used as an excuse to diminish the government's commitment to Medicare beneficiaries.  
41

42 7. A reassessment of the voucher program should be required after five years.  
43 This reevaluation should be undertaken by an agency or commission not  
44 responsible for funding Medicare.  
45

46 Given the untried nature of a voucher program for Medicare, there should be an evaluation of the  
47 program relatively early in its life. There was little comprehensive evaluation of the original  
48 Medicare program in its early stages and many of the present troubles in the system derive from  
49 that oversight. If the voucher program does not seem to be living up to its expectations,

1 Congress and the administration should not merely tinker at the edges to provide short term fixes  
2 but should step back, take a hard look at the program and even consider starting all over again.  
3

4 8. Beneficiaries opting for the voucher program should be provided incentives that  
5 encourage their selection of an economically priced plan but that do not force  
6 enrollees into those plans that are most restrictive of choice of physician and that  
7 impose the strictest limits on access to services. Incentives should come in the  
8 form of additional benefits or services provided by the health plan and not in the  
9 form of a cash rebate. With rules in place to ensure that all beneficiaries have  
10 access through voucher plans to the full range of Medicare covered benefits and  
11 services, beneficiaries should pay the difference between the voucher amount and  
12 any premium charged by a plan that exceeds the voucher amount.  
13

14 Some analysts contend that beneficiaries should be provided incentives to select a health plan  
15 that costs less than the federal contribution amount, or voucher. These incentives typically fall  
16 into two categories—cash rebates or additional services. Giving beneficiaries a cash rebate if their  
17 premium is less than the voucher amount would remove funds from the health care system that  
18 ought to be providing for health care services. Instead, any excess value should be returned to  
19 the beneficiary in the form of additional benefits such as coverage of additional services,  
20 providing coverage for long term care or creating a health care spending account. There is also  
21 debate over whether beneficiaries should bear the full cost of a health plan more expensive than  
22 the voucher to encourage enrollees to select more economical health plans. Although there is  
23 concern that such an incentive might drive beneficiaries to select plans of lesser quality or that  
24 don't cover the full range of benefits, this is less of a problem if all plans offer the full range of  
25 Medicare-covered services.  
26

27 9. Reasonable cost sharing under voucher plans – both fee for service and  
28 managed care – should be imposed to assure consumer cost consciousness in  
29 utilization of services. Lower cost sharing should be imposed on clinically-proven  
30 preventive services so that people are not unduly discouraged from obtaining  
31 beneficial care. Preventive services should be subject only to copayments, not  
32 deductibles. Copayments for preventive services should be set lower than those  
33 for other services.  
34

35 To avoid unjustified restrictions on choice of physician, POS voucher plans should  
36 not impose unreasonable coinsurance on services provided by out-of-network  
37 physicians. To prevent beneficiaries who seek out-of-network care from being  
38 subject to unexpected out-of-pocket costs, POS plans and physicians should be  
39 required to establish their own conversion factors to be used against an improved  
40 resource based relative value scale (RBRVS). This would determine the rates the  
41 POS plan would pay and the fees the physicians would charge for their services.  
42 Plans and physicians would be required to supply enrollees in the POS plan with  
43 information based on these conversion factors to enable enrollees to determine in  
44 advance how much they would pay in going out of the plan's network of  
45 physicians.  
46

47 As an incentive to promote greater price consciousness in the traditional Medicare  
48 program and to encourage the movement of beneficiaries into the voucher system,  
49 those who choose to stay in the traditional Medicare program should be subject to

1 reasonable and non-punitive increases in cost-sharing. As with POS plans, in  
2 order to buffer beneficiaries from unexpected costs, a requirement could be  
3 imposed under traditional Medicare that physicians must establish their conversion  
4 factor for their services each year concomitant with the announcement of  
5 Medicare's conversion factor. Enrollees in traditional Medicare would be supplied  
6 annually with information comparing the charges of physicians in their area to  
7 Medicare's fees based on their respective conversion factors. In this fashion,  
8 beneficiaries would know in advance whether or not they would have to pay out-  
9 of-pocket for services charged under traditional Medicare.

10  
11 Beneficiaries should not be subject to charges in excess of Medicare's payment  
12 amounts under the following circumstances: in the case of low income  
13 beneficiaries; emergency situations; when the beneficiary has little voice in the  
14 selection of a physician or in areas of the country where there is no competition for  
15 a particular medical specialty.  
16

17 If true reform is to be instituted in the Medicare system, enrollees must understand the nature of  
18 the costs of their care under that program. At the same time, policymakers should not lose sight  
19 of the fact that 83 percent of Medicare expenditures go to beneficiaries with incomes at or below  
20 \$25,000 and thus their exposure to additional costs should be limited.

21  
22 ASIM believes it is especially important that cost sharing on preventive services be reduced and  
23 deductibles on these services be eliminated entirely to avoid discouraging patients from obtaining  
24 necessary care. By erecting barriers to cost-effective preventive care—for example, imposition of  
25 cost sharing on mammograms—patients may avoid those services and wind up with more serious,  
26 and expensive, illnesses in the future.

27  
28 In addition, ASIM supports limits on the degree to which additional cost sharing can be imposed  
29 on those enrolled in managed care plans who use a plan's point-of-service (POS) option to seek  
30 care outside the plan's network of physicians. The intent behind POS is to allow beneficiaries  
31 greater choice in physician and provider. If the cost sharing imposed on a beneficiary for going  
32 outside a health plan's physician network is excessively burdensome, then the promise of greater  
33 choice is a hollow one.

34  
35 Obviously, if beneficiaries are to be encouraged to enter the voucher program, those who opt to  
36 stay in traditional Medicare must bear a greater share of the cost of remaining in the more  
37 expensive program. Nevertheless, any additional cost sharing should follow the principles stated  
38 above so that primary care and preventive services are sheltered from deductibles and are  
39 subject to cost sharing at a rate lower than that imposed on other services. Because high  
40 deductibles can act as a disincentive for patients to receive needed primary care and preventive  
41 services, ASIM does not support replacing the current coinsurance requirements under traditional  
42 Medicare with a single high deductible.

43  
44 ASIM believes that its Competitive Pricing, Informed Choices proposal—issued in 1992—offers a  
45 means to instill price competition among physicians, enhance consumer cost consciousness and  
46 prevent price gouging by unscrupulous providers. If health plans that pay according to a fee  
47 schedule (POS plans, traditional Medicare, indemnity insurers) and physicians were required to  
48 set and publish the conversion factors they would use each year to determine their charges and  
49 fees, this information could be used by beneficiaries to determine what they would pay out-of-

1 pocket, if anything, if they joined a particular health plan or used a particular doctor. Beneficiaries  
2 would then be able to decide if the value they derived from a health plan and/or physician in  
3 terms of quality and service was worth the price of any additional costs.  
4

5 For example, assume Mrs. Jones is a Medicare beneficiary who receives from HCFA a booklet  
6 listing all the health plans and physicians in her area. Among the information contained in the  
7 booklet might be the percentage difference between the conversion factors used by traditional  
8 Medicare and POS plans and the physicians listed in the booklet. Mrs. Jones might see that Dr.  
9 Smith has a conversion factor 10 percent higher than Medicare's conversion factor. If she went to  
10 Dr. Smith for care under traditional Medicare, she would know that she would pay an additional  
11 ten percent on Dr. Smith's charges beyond the payment traditional Medicare would make. Or,  
12 Mrs. Jones might see that health plan ABC has a conversion factor for its POS option 20 percent  
13 lower than Dr. Smith's conversion factor. She would then know that Plan ABC would pay 20  
14 percent less for the services of Dr. Smith—who does not participate in her health plan physician  
15 network—and she would be responsible for the 20 percent difference between the health plan's  
16 payments and Dr. Smith's fees, in addition to any additional cost sharing required by Plan ABC for  
17 enrollees going out of the network.  
18

19 While ASIM generally supports cost sharing by patients in order to enhance cost consciousness in  
20 the utilization of scarce health care resources, there are situations in which billing beyond  
21 Medicare's payment rates or additional cost sharing should not be imposed. These situations  
22 arise where beneficiaries' income is simply too low to sustain any additional out-of-pocket  
23 financial burden, where they have no opportunity to "shop around" for a physician (e.g.  
24 emergency situations), where beneficiaries have but one choice of physician (such as typically  
25 occurs during hospitalizations when patients are essentially assigned certain hospital-based  
26 doctors to deliver designated services) or where there are so few physicians in a particular  
27 specialty within a community that there is no chance for competition among physicians to operate.  
28

29 10. To qualify as a voucher plan under Medicare, health plans should have to:  
30 offer a standard minimum Medicare benefits package that includes preventive  
31 services; meet certain utilization review and quality assurance standards; involve  
32 participating physicians in development of the plan's utilization review (UR) and  
33 quality assurance (QA) and provider selection policies and procedures; disclose  
34 their utilization review and quality assurance policies, restrictions on choice, risk  
35 arrangements and provider selection criteria; establish due process mechanisms in  
36 selection of plan providers; meet certain solvency standards; report certain  
37 information — such as premium costs, out-of-pocket liability, consumer satisfaction  
38 and the percentage of premium dollars devoted to administration versus benefits —  
39 to a central data collection entity so that this information can be distributed to  
40 beneficiaries and use uniform claims forms and standard billing and claims  
41 processing procedures.  
42

43 Health plans that selectively contract with physicians should be required to offer  
44 enrollees the opportunity to buy a rider that provides point-of-service access to  
45 non-network physicians, in addition to meeting the foregoing standards.  
46

47 Health plans should play by the same rules if competition is truly to be effective in controlling  
48 costs. Given that the idea behind many Medicare voucher proposals is to enhance competition  
49 within the program so as to bring down costs, it would seem equally advisable that health plans

1 should be required to meet certain rules if they wish to participate in the voucher program and  
2 market themselves to beneficiaries as Medicare voucher plans.  
3

4 A uniform minimum benefit policy would assure a basic level of care for all beneficiaries. In  
5 addition, it would facilitate beneficiaries' comparison of health plans. If beneficiaries are to have  
6 sufficient information to make informed choices with their vouchers, they will need data on a  
7 plan's costs, patient out-of-pocket liability, provider panels, and quality. Furthermore, disclosure  
8 of UR and selection standards benefits not only the providers involved with a health plan but  
9 helps beneficiaries as well by giving them another piece of information on which to compare  
10 health plans.  
11

12 In addition, it is important that physicians have a role in developing and implementing health plan  
13 policies and procedures that directly affect clinical decision-making—e.g. benefits coverage  
14 criteria, determination of medical necessity, preauthorization of services, quality assurance  
15 standards, protocols and processes for selection and deselection of physicians. To leave  
16 decisions affecting patient care solely in the hands of health plan administrators whose concerns  
17 center largely on cost containment may jeopardize the quality of care given to enrollees and deny  
18 patients access to medically necessary services. Furthermore, health plans that involve  
19 physicians in development of these policies are far more likely to obtain the cooperation of their  
20 network physicians in proper implementation of those policies.  
21

22 Finally, it is important that voucher plans be required to operate under similar billing and claims  
23 processing procedures to avoid unnecessary red tape. All plans that currently operate within the  
24 Medicare system must abide by the uniform claims form and billing rules and it would be logical  
25 to expect that voucher plans should use a standard format and follow standard claims processing  
26 procedures for this new variation of the Medicare program.  
27

28 The type of standards to which ASIM refers—involvement of physicians in clinical policymaking,  
29 providing information to enrollees and prospective enrollees sufficient to enable them to make  
30 informed decisions about the plan—are, in fact, those that are being adopted by many well-run  
31 health plans in today's marketplace. In a competitive environment, those plans that pursue  
32 "patient-friendly" policies such as these are more likely to succeed than others.  
33

34 11. Because Medicare is a federally funded program, the federal government must  
35 continue to ensure that health plans are accountable for the care they give to  
36 beneficiaries and that they abide by standards set out for Medicare plans. HCFA  
37 or another federal agency should be responsible for contracting with health plans;  
38 reviewing marketing materials; disseminating to beneficiaries objective data about  
39 each plan in a region in a standard format; ensuring health plan compliance with  
40 certain standards governing their rules and operations; and ensuring that health  
41 plans meet certain quality standards. However, private accreditation agencies  
42 should be able to achieve "deemed" status to fulfill the role played by HHS in  
43 approving voucher plans. Mechanisms should be available for patients and  
44 physicians to pursue grievances against health plans for denial of medically  
45 necessary care. Patients and physicians should retain access to fair hearing and  
46 judicial review processes at least comparable to those now available under  
47 traditional Medicare.  
48

1 Because vouchers would require more thought and decisionmaking by Medicare recipients, some  
2 analysts question whether beneficiaries would find the voucher program truly appealing. Other  
3 policymakers argue that the basic premise of the voucher program is simple and that most  
4 beneficiaries, given the right kind of information, will be able to make proper decisions about a  
5 health plan. While this may indeed be the case for healthy beneficiaries who are mentally alert,  
6 the frail and disabled elderly, those who do not speak English very well or those with little  
7 education may find the task of sorting through health plan information daunting. To respond to  
8 some of these concerns, the voucher program should have an entity with which voucher plans  
9 would contract and which would ensure voucher plan adherence to any standards adopted  
10 governing such plans.

11  
12 Given the characteristics of the Medicare population, an ombudsman's office should be created  
13 to receive, investigate and resolve complaints against voucher plans as well as to offer guidance  
14 to beneficiaries with questions about the voucher program. Finally, beneficiaries and physicians  
15 should retain access to the current Medicare appeals process.

16  
17 ASIM would prefer that the health care industry voluntarily abide by the standards established for  
18 a voucher program and, indeed, supports the idea of a private accreditation body responsible for  
19 ensuring health plan adherence to voucher program standards. However, the voucher program  
20 will be funded by federal dollars and the federal government should not relinquish its  
21 responsibility for ensuring that health plans are accountable for the care they deliver to  
22 beneficiaries and for seeing that corrective actions are taken when deficiencies are found if a plan  
23 wishes to remain in the voucher program. Health plans that accept the government contributions  
24 should understand that, if they are going to compete for the business of the federal government  
25 through the voucher program, they must accept certain standards and certain reasonable  
26 oversight.

27  
28 **12. Self-referral restrictions affecting shared laboratory facilities and group**  
29 **practices should be removed and antitrust reforms enacted to enable physicians**  
30 **and providers to negotiate on an equal footing with health plans and purchasers.**

31  
32 Antitrust reforms and other modifications to statutory restrictions on physicians could improve the  
33 functioning of health plans offered under a voucher system and the ability of physicians to deliver  
34 services within their context. For example, self-referral restrictions on group practice  
35 compensation arrangements not only interfere in the internal affairs of private businesses but lead  
36 to confusion over how such practices may distribute revenue from ancillary services without  
37 indirectly taking into account the referrals made by physicians. Furthermore, subspecialists—such  
38 as oncologists and infectious disease specialists—in many group practices are barred from  
39 providing drugs and other services to their patients because of the self-referral laws.

40  
41 Limitations on the ability of physicians to share information in order to form integrated service  
42 networks may impede the goals of voucher advocates who wish to foster competition that reduces  
43 the cost of care and increases benefits to attract voucher recipients. Indeed, antitrust laws  
44 developed at a time when most physicians and other providers practiced independently of one  
45 another now prevent these caregivers from organizing preferred provider organizations, health  
46 plans and other delivery networks that would enable physician-directed health care organizations  
47 to compete in the marketplace and offer beneficiaries a wider choice of health care options.  
48  
49

1 **Conclusion**

2  
3 ASIM is under no illusion that reforming Medicare will be simple, easy, or quick. Changes of the  
4 magnitude required to place the program on sound financial footing and to guarantee that  
5 beneficiaries continue to receive the high quality health care to which they have become  
6 accustomed and to which they are entitled will require a great deal of thought and debate. For  
7 ASIM, the overarching philosophy on which these Medicare reform proposals rest is that of shared  
8 responsibility.

9  
10 Physicians have a responsibility to deliver care to greater numbers of Medicare patients under  
11 health care delivery systems that will increasingly require them to accept financial risk and to be  
12 accountable for the cost and quality of their clinical decisions--and to compete within this new  
13 system on the basis of cost and quality.

14  
15 Medicare patients have a responsibility to consider the costs of alternative sources of health care  
16 coverage, to be willing to contribute more in out-of-pocket costs if they choose more expensive  
17 coverage and--for those who can afford to--to contribute more to the financial support of Medicare  
18 so that those of lesser means can afford coverage.

19  
20 Taxpayers have a responsibility to accept changes in the tax code that would raise revenue and  
21 introduce positive incentives into the health care system including a limit on the tax deductibility of  
22 employer paid insurance and increased taxes on tobacco.

23  
24 The insurance industry has a responsibility to compete in the new system--not solely on price or  
25 risk avoidance but on benefits offered and quality--and to accept reasonable standards to protect  
26 beneficiaries who choose private insurance coverage.

27  
28 And the federal government has a responsibility to assure that the government's contribution  
29 remains adequate to guarantee that all beneficiaries can obtain high quality coverage through  
30 traditional Medicare and private sector alternatives--and to provide sufficient oversight over the  
31 market to protect patients' interests.

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## Alternative Updates and Conversion Factors for the Medicare Fee Schedule in 1996

### CURRENT

	SURGERY	PRIMARY CARE	OTHER NON-SURGERY
Current 1995 Conversion Factors	\$39.45 (vs. primary care: +8.4%, vs. other non-surgery: +14.0%)	\$38.38	\$34.82

### DEFAULT

	SURGERY	PRIMARY CARE	OTHER NON-SURGERY
1996 Default Updates	3.9%	-2.2%	.6%
1996 Conversion Factors Under the Default Updates	\$40.99 (vs. primary care: +15.2%, vs. other non-surgery: +17.7%)	\$35.58	\$34.89

### PPRC/HHS

	SURGERY	PRIMARY CARE	OTHER NON-SURGERY
PPRC/HHS Recommended Updates	1.1%	1.1%	1.1%
1996 Conversion Factors Under PPRC/HHS Recommendations	\$39.88 (vs. primary care: +8.4%, vs. other non-surgery: +14.0%)	\$38.78	\$35.00

### SINGLE CONVERSION FACTOR IN 1996

	SURGERY	PRIMARY CARE	OTHER NON-SURGERY
Budget neutral updates that would result in a single conversion factor in 1996	-6.1 %	1.8%	7.0%
Budget neutral single conversion factor in 1996	\$37.03	\$37.03	\$37.03



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**Statement  
of the  
American Hospital Association  
before the  
Subcommittee on Health and the Environment  
of the  
House Commerce Committee  
of the United States House of Representatives  
on  
Medicare Budget Issues**

**July 18, 1995**

Mr. Chairman, I am Dick Davidson, president of the American Hospital Association. The AHA includes in its membership 5,000 hospitals, health care systems, networks and other providers of care. I am pleased to testify on their behalf about how the tough decisions you will be making could, if based on the principles I'm about to outline, result in a more effective and efficient Medicare program.

Congress has decided on its destination: a balanced budget by the year 2002, including \$270 billion in Medicare savings. Now comes the hard part -- getting there. America's hospitals and health systems have long recognized that the brakes must be applied to a budget deficit that is running out of control. However, we remain deeply concerned about the magnitude of proposed reductions in Medicare and Medicaid spending. But we are committed to working toward a solution that takes us to our national goal of fiscal responsibility without sacrificing the promise of health care protection for older, disabled, and poor Americans.

-2-

Hospitals and health systems worked with the Senate Entitlement Task Force to develop an approach that would save \$160 billion in Medicare spending over seven years, mostly through restructuring the program. And we've worked with the Republican leadership on how we can achieve further efficiencies in the program by dramatically changing the way medical services are provided and paid for.

Now, authorizing committees such as this one will try to chart a course to get Congress to its balanced budget destination. To help you along the way, hospitals and health systems offer a road map -- our four principles for the reconciliation process that we believe can help improve the entire health care delivery system -- and, at the same time, strengthen the Medicare program for older Americans and the people who provide their care.

These are our four principles:

- Change the delivery system to encourage more use of coordinated care -- cooperating groups of hospitals, doctors, and others who knit the fragmented delivery system together for patients and have powerful incentives to control costs.
- Change the process by which Medicare benefit and funding decisions are made.
- Make sure all stakeholders absorb spending reductions.
- Ensure access to high-quality health care for our most vulnerable populations -- the elderly, poor and disabled.

-3-

These principles have guided us throughout the budget process. The nation's hospitals and health systems hope that they will guide you as you make the tough choices required in the weeks ahead.

### Change the delivery system

This is probably the most fundamental and essential of our principles. Quite simply, the Medicare program is a dinosaur. Change has infiltrated almost every aspect of the private health care sector, and public programs like Medicare must catch up to be effective in the future. The key is to restructure Medicare to encourage more use of coordinated care. Coordinated care is working in the private sector, and it can work in Medicare as well.

Coordinated care's responsibility for a range of health services can improve quality because an entire network of providers is held accountable for a patient's care. Coordinated care can also cut costs by shifting the focus of health care from sickness to wellness. Hospitals and health systems support efforts to make available to older Americans the same care, plan options, and health plan information that is available in the private market. Medicare must take advantage of the efficiencies that have been achieved in the private sector. Here's how Congress can help the program do that:

- **Expand the types of plans that Medicare beneficiaries can choose --** Currently, beneficiaries can choose care through some health maintenance organizations (HMO) or from traditional fee-for-service providers. Medicare should also contract with the

-4-

growing number of non-HMO networks of care that meet high standards for quality and public accountability, and offer a full continuum of services for a fixed premium. New kinds of contracts could be negotiated with these non-HMO networks in which the networks and the Medicare program would share risk.

- **Provide seniors with more information on health care plans** -- send information on available health care plans directly to Medicare enrollees. Give them an annual report that compares coordinated care plans to fee-for-service plans on the basis of premiums, supplemental benefits, cost sharing, and quality ratings. This will make seniors more knowledgeable consumers and will highlight the benefits of coordinated care.
- **Provide financial incentives for beneficiaries who choose coordinated care options** available in their area. In most areas, these plans offer comprehensive services at lower than current fee-for-service prices. They often give seniors better value for their Medicare dollars by eliminating co-pays in deductibles or adding benefits such as prescription drugs.
- **Allow for an open enrollment period each year, during which Medicare beneficiaries** can elect to receive services from a coordinated care plan. And make their choice of a coordinated care plan valid for one year instead of the current 30-day period. That will enable the plan to better manage the patient's needs and practice preventive care.

-5-

- **Model Medicare after the Federal Employees Health Benefit Program --** The government makes a fixed contribution and the federal employee chooses from a wide variety of plans. Medicare could do the same for its beneficiaries.
- **Fix the current methodology used to pay Medicare risk contractors --** The current payment system is flawed; Congress has directed the Health Care Financing Administration (HCFA) to propose revisions by October. Current payment is based on the Adjusted Average Per Capita Cost (AAPCC) of care in a county, and it can vary from place to place. Medicare should eliminate geographic inequities in payment across counties, inequities due to variable health status of local populations, and inequities due to differential utilization of services in local areas, which affects costs and the calculation of the AAPCC.

At the same time, Congress must eliminate barriers that discourage the creation of coordinated care networks by inhibiting provider cooperation -- the heart of coordinated care.

For instance:

- **Physician self-referral law (known as Stark I and Stark II),** which prohibits referrals when a financial relationship exists between the physician and the entity to which the physician refers a patient, is unclear. It must be modified. The original goal -- to prevent physicians from referring patients for unneeded services based on the potential for financial gain -- remains valid. But the law was drafted in a different era of

# American Medical Association

Physicians dedicated to the health of America



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## Statement

to the

House Commerce Committee  
Subcommittee on Health & Environment

**Re: The Future of the Medicare Program**

Presented by: Lonnie R. Bristow, MD

July 18, 1995

Division of Legislative Counsel  
202 789-7426

Good morning, Mr. Chairman, and thank you for the opportunity to testify before you on the subject of restructuring the Medicare program. As Medicare approaches its thirtieth birthday, I think it is especially appropriate that we have this discussion. Medicare is a successful and popular program which has significantly improved the lives of the vulnerable population it serves. Our challenge is to work together to improve the program's success and strengthen Medicare so it continues to thrive for every generation.

Any discussion of reforming Medicare must begin with an examination of those features of the program worth keeping, as well as those in need of change. Three features of the Medicare program, in particular, constitute the core of its protection for senior and disabled citizens and must be preserved.

First, Medicare coverage is available to everyone, regardless of health status. Beneficiaries cannot be denied or charged more for Medicare coverage because of their health status or preexisting conditions. Indeed, disabled citizens are entitled to Medicare coverage because of their health status. This security of Medicare coverage must not be compromised. It is fundamental to the contract our nation has made with our elderly and disabled citizens.

Second, Medicare guarantees a basic level of coverage to all beneficiaries. Medicare covers medically necessary hospital, physician, skilled nursing and home health services and equipment. For this coverage, beneficiaries contribute payroll taxes during their working lives and pay premiums after retirement. However, because Medicare coverage is limited, most beneficiaries feel compelled to obtain supplemental coverage through private medigap insurance, and some low income beneficiaries have coverage supplemented by Medicaid. As a result, today seniors pay, on average, 21 percent of their incomes for out-of-pocket health care expenses. This is a very significant amount, and we must never forget that fact. Cuts in Medicare coverage of the magnitude the Republicans have specified -- whether in the form of reduced benefits, significantly increased cost sharing and premiums, or allowing doctors to increase balance billing -- would seriously hurt beneficiaries and would be strongly opposed by the Administration.

The \$270 billion in Medicare cuts that the Republicans have proposed is three times anything previously enacted. A quick review of the Republican Medicare reform working document suggests that Medicare beneficiaries would be required to pay substantially more to keep their current coverage and access to their doctors. Specifically, preliminary HCFA estimates show such beneficiaries would need to pay \$403 more in Part B premiums

than they would under the President's plan. Additionally, they would face new coinsurance on home health and skilled nursing care that would cost the average person using these services in excess of \$1,000 for each benefit.

Third, Medicare buys meaningful access to health care. A Medicare card today guarantees access to virtually every hospital and physician in the country. Choice of caregivers and health care institutions is important to all Americans, but it is even more important to the elderly and disabled Medicare populations given their multiple and complex health problems. Efforts to control Medicare spending over the years have had to strike the balance between cost containment and maintaining access to mainstream care. Sustaining that balance remains critically important.

As important as it is to the well-being of 37 million Americans, the Medicare program as we know it is not perfect. Strengthening reforms in several key areas are desirable.

The first reforms are to expand beneficiary choice. - Today Medicare offers a choice between managed care and traditional fee for service coverage. More than 70 percent of enrollees have access to managed care, and more than half have a choice of two or more managed care options. Medicare managed care enrollment is growing at a rate of one and one-half percent per month. In the first six months of this year we have already seen a 9 percent overall increase in managed care enrollment, and by the year's end expect an 18 percent increase in enrollment. More than 250 managed care organizations -- 165 on a risk basis -- currently contract with HCFA to serve Medicare beneficiaries. Still, we can do more.

As we have testified previously, we are working to expand choices for Medicare beneficiaries. The Health Care Financing Administration (HCFA) has announced "Medicare Choices," a new demonstration project designed to expand the types of managed care plans available to Medicare beneficiaries and to test different payment methods. We also support opening the Medicare program to participation by Preferred Provider Organizations (PPOs.) To enhance managed care choices, HCFA also is working on improvements and alternatives to the Adjusted Average Per Capita Cost (AAPCC), the existing method of paying Medicare HMOs. Using competitive pricing as an alternative to the AAPCC is one method currently under development.

Second are reforms to promote quality. - We continue to strengthen our Peer Review Organization (PRO) quality review for traditional fee for service Medicare. Our move to the new Medicare Transactions System (MTS) also will provide better data on the services all Medicare beneficiaries receive so that stronger quality assurance programs can be developed. To

strengthen quality assurance for those beneficiaries enrolled in managed care, HCFA has embarked on a number of initiatives. For example, HCFA has joined with the private sector, the Department of Defense, and others to improve managed care quality and plan accountability. We expect to complement existing quality assurance and accrediting organizations, such as the National Committee for Quality Assurance and the Joint Committee for the Accreditation of Health Organizations, and have received their support.

Third are reforms to protect against fraud and abuse. - The Administration recently transmitted to the Congress our proposal for an innovative anti-fraud and abuse effort known as Operation Restore Trust. This plan would enhance the ability of HCFA and our carriers and intermediaries to combat fraud in the Medicare program, in particular by relying on improved payment screens rather than old pay-and-chase methods. Administration witnesses will provide you with a more detailed description of Operation Restore Trust at your hearing on fraud and abuse tomorrow.

Fourth are reforms to contain costs and enhance benefits. - Finally we continue to pursue reforms to control program costs while protecting access to care, the quality of care, and beneficiary choice. In his balanced budget proposal, President Clinton called for \$124 billion in net Medicare savings over seven years. Some of the savings are used to finance improvements in coverage. Specifically, cost sharing would be eliminated for mammograms to improve use of this important preventive service; and a new respite care benefit would be available for families of beneficiaries with Alzheimer's disease.

The savings proposed by the President would not only help to reduce the budget deficit but, equally important, they would extend the life of the Medicare trust fund through at least 2005. No new savings would come from an increase in beneficiaries' out-of-pocket costs. As the President has promised, we are ready to work with the Congress to achieve these savings while protecting access, quality and choice. We will fight changes that threaten these goals.

### Vouchers

Our efforts in the areas of choice, quality of care, fraud and abuse and cost containment are intended to build upon the choice, coverage, and access that are the foundations of Medicare. As such, they need to be distinguished from Republican efforts to reform Medicare that are more concerned with meeting arbitrary budget targets than with beneficiaries' needs.

Let me be clear. Republican proposals to shift to a voucher system are about reducing federal spending by \$270 billion at beneficiaries' expense. They are not about reforming Medicare. Talking about these proposals in terms like "defined contribution" and "FEHBP-like" imply that vouchers are mainstream and safe. But any voucher plan based on \$270 billion in Medicare cuts can only be disastrous to beneficiaries' security and an abrogation of our 30 year contract with elderly and disabled Americans.

Some have proposed that Medicare should be restructured to look more like the Federal Employees Health Benefit Program (FEHBP). We, too, believe that beneficiaries should have as broad a range of choice as offered in the FEHBP. But we also know that the purchasing power and health care needs of the Medicare population are very different from younger, healthier, and employed FEHBP enrollees'. Furthermore, health coverage through the FEHBP is an employee benefit. Medicare, like Social Security, is a social contract that guarantees beneficiaries coverage in return for contributions made throughout their working years.

Finally under FEHBP, the government's contribution is determined by the costs of the participating plans. It is not a fixed dollar amount, indexed to a predetermined annual growth rate. While Congress is contemplating changes in the way the government's contribution to FEHBP is calculated, it is important to note the Republican voucher plan as outlined by the Shays Task Force would not give Medicare beneficiaries the protection that members of Congress now enjoy through the FEHBP.

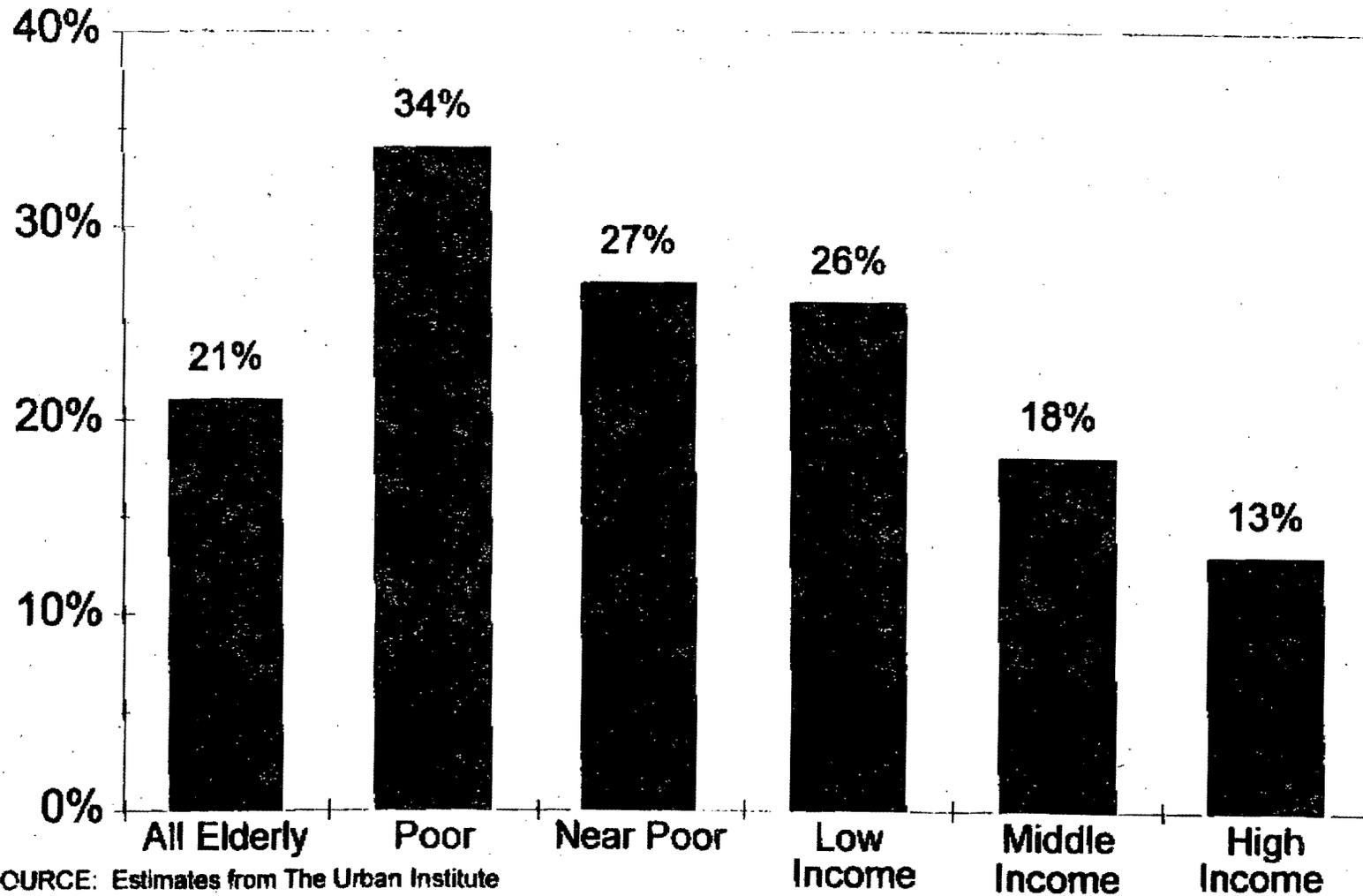
Private health care spending per insured person will grow at 7.1% per year from 1996 to 2002 according to CBO data. In contrast, the level of Medicare cuts in the Republican budget conference agreement suggests that the Republican voucher payment would grow at only 4.9 percent per year. That means that every year, for every Medicare beneficiary, the cost of what they'll need to buy will grow faster than the voucher Republicans would give them to buy it with.

What would the Republican voucher proposal really mean to beneficiaries? At best they would likely have to pay more to keep the coverage they have today. However, since three-fourths of Medicare beneficiaries have incomes below \$25,000, it is likely that many seniors would not be able to pay more. At worst, beneficiaries would be forced to buy coverage that is insufficient to meet their needs. That's not choice; it's financial coercion.

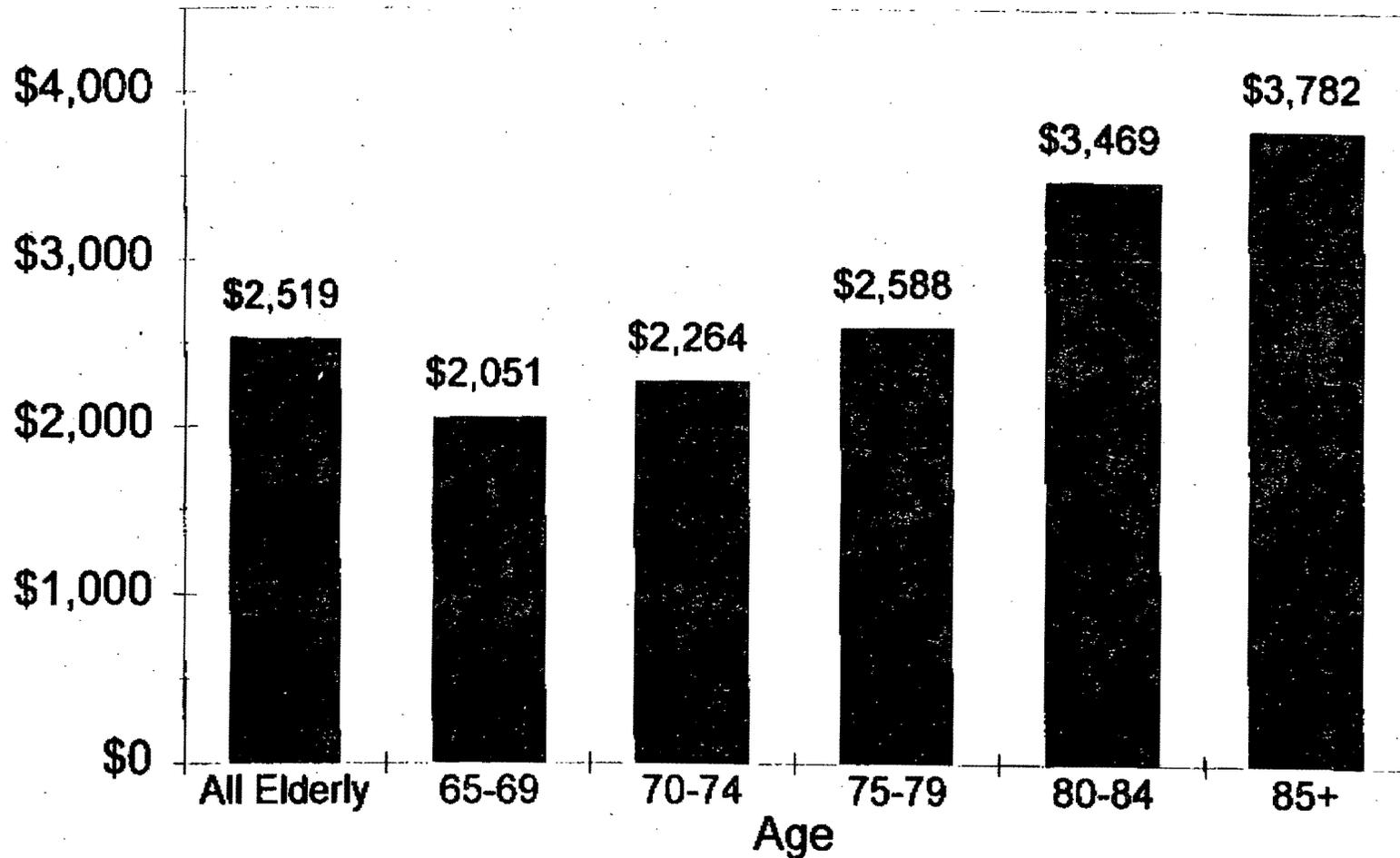
## Conclusion

This Administration is committed not only to strengthening the Medicare program, but also to preserving the fundamental protections the program provides. In evaluating any structural changes to Medicare, this Committee must join us in this resolve. Medicare enrollees must continue to be assured coverage regardless of health status. A basic level of benefits must be guaranteed, as it is today. And access to and choice of caregivers must be maintained. The Republican voucher proposal that is designed to produce \$270 billion in savings does not meet these standards. Instead, it would turn back the clock 30 years to a time when the elderly and disabled struggled in a discriminatory and expensive insurance market to buy decent coverage with limited funds. We can and must do better.

# Average Out-of-Pocket Health Costs for the Elderly, by Income: 1994

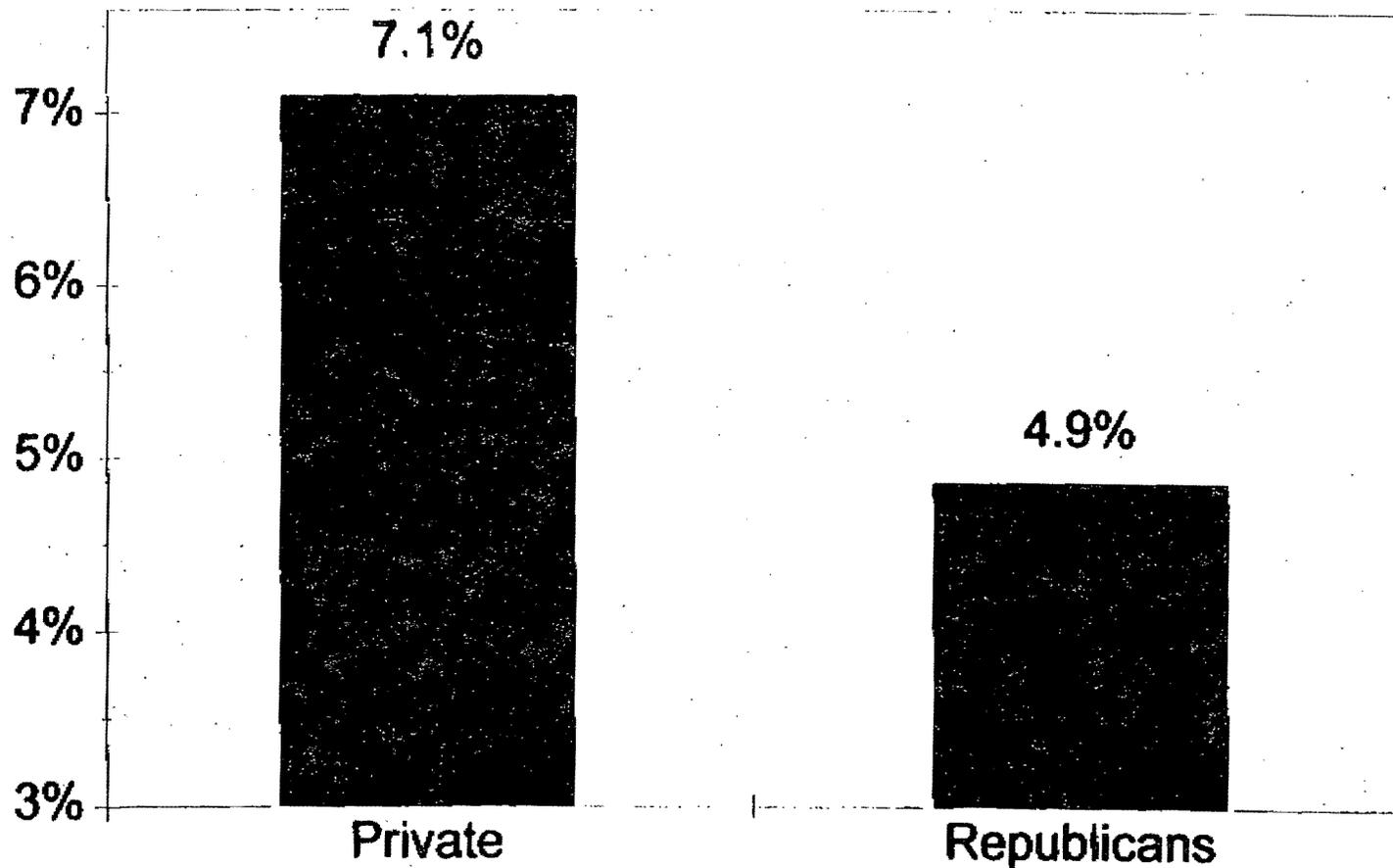


# Average Out-of-Pocket Health Costs for the Elderly, by Age: 1994



SOURCE: Estimates from The Urban Institute

# Private Sector Health Plan versus Republican Medicare Growth per Beneficiary, 1996-2002



All estimates are calculated by the Administration using CBO data.

**STATEMENT**  
**of the**  
**AMERICAN MEDICAL ASSOCIATION**  
**to the**  
**HOUSE COMMERCE COMMITTEE**  
**SUBCOMMITTEE ON HEALTH & ENVIRONMENT**

**RE: The Future of the Medicare Program**

**Presented by: Lonnie R. Bristow, MD**

**July 18, 1995**

Mr. Chairman, my name is Lonnie R. Bristow, MD. I am an internist from San Pablo, California, and President of the American Medical Association (AMA). On behalf of the 300,000 physician and medical student members of the AMA, I thank you for the opportunity to present testimony to the Subcommittee today regarding the AMA's proposal to transform Medicare. We are pleased to share our thoughts with you as the Congress considers how to best protect the promise of Medicare in an era of sharply limited resources.

A wide range of experts have independently concluded that, despite Medicare's clear success in improving the health status of our elderly and disabled citizens, the program cannot be sustained without a fundamental restructuring. The AMA has testified before this subcommittee earlier this year regarding those factors precipitating Medicare's current crisis. The time has passed for tinkering and minor modifications. In light of what is known about the program's structural flaws and its looming bankruptcy if basic reforms are not made, the AMA has synthesized almost ten years of policy consideration and research by our association into the proposal we will describe to you today and which has been distributed to every Member of the Congress. It is based on principles that the AMA has repeatedly advocated for

reforming Medicare to correct current structural problems and to reduce the dependency of future generations on subsidized government medical care.

The reforms we propose are a fundamental shift away from government control toward personal responsibility, individual choice and an invigorated Medicare marketplace. The AMA's proposal is based on the idea of a competitive market-driven system as the best option for the future of the Medicare program because it offers more choice to senior citizens and the disabled. We must give the patient both the opportunity and the responsibility to make wise prospective choices of physician and financing mechanism, with the reasonable opportunity to change either if they prove unsatisfactory. An effective health care marketplace is only achievable if we rid ourselves of the current program's distortions that have had the perverse effect of aggravating, rather than easing, the government's burden in keeping Medicare's promise. As long as Medicare insulates patients from the true cost of the services they are consuming, a competitive Medicare marketplace will never flourish and costs will continue to escalate.

### AMA'S PROPOSAL FOR MEDICARE TRANSFORMATION

Distilled to two central ideas, AMA's proposal is premised on the belief that:

- **Individual responsibility, changed incentives and reduced administrative costs will produce savings for most patients and lead to the fiscal integrity of the Medicare program; and**
- **Medicare beneficiaries – our patients – should have enhanced choice and the ownership and responsibility for their Medicare entitlement, while receiving the highest quality medical care.**

## SAVINGS

How can a system premised on choice and individual responsibility offer savings to the Medicare program? When individuals have a financial stake in their medical care, they are more likely to be prudent consumers and seek the highest value for their money. Patients and physicians alike become sensitized to price and, more important, value. When marketplace distortions are eliminated through the removal of government price controls, physicians and other providers will compete in the marketplace. The private sector has demonstrated that competition can yield savings.

These savings are the result of a more prudent use of resources by patients, coupled with increased efficiency by physicians. **Enhanced beneficiary cost-consciousness does not have to mean substantial increased costs for beneficiaries. It is primarily the manner in which beneficiaries pay today -- not the amount -- that defeats any incentive to use the program efficiently.** Our proposal will actually bring an estimated 40% of beneficiaries some level of savings. It will leave about half of beneficiaries no better or worse off than if they had remained under the current system, and it will call on an estimated 10% to pay marginally more. This benefit accrues while simultaneously saving the program billions of dollars. (See attached chart demonstrating overall projected net savings achieved through these changes, as well as the effect on simulated low and heavy users of health care services.)

**Nor do these savings have to come from a continuation of past failed policies repeatedly reducing physician payments.** Physicians have, year after year, contributed their fair share to the budget deficit effort. Physicians, who account for 23% of Medicare outlays, have absorbed 32% of Medicare provider cuts over the last decade. Projected further declines, based on the current flawed payment formula, will actually bring physician payments lower, at the end of the century, than they were at the beginning of the 1990s when RBRVS was first implemented (see attached

chart). Our proposal achieves savings while minimizing further reductions that will push many physicians over their own budgetary red line, reducing or eliminating entirely their ability to continue caring for Medicare patients. Competition requires that prices be decontrolled and beneficiaries rewarded for seeking better value in the marketplace. Our proposal for physician price competition builds on the current RBRVS-based system. We call on the Secretary of HHS to design a similar system for DRG-based hospital payments in the HI program, as well.

Some have mistakenly portrayed the AMA's plan as allowing for "balance billing." This is an inaccurate and misleading characterization, as the concept of "balance billing" is a remnant of the government "command and control" system which we are attempting to transform. This old system perversely serves to penalize physicians for setting their prices too low. The AMA's proposal would allow the government to set its price, physicians to set their conversion factor, and patients to compare value among competing caregivers. Given that approximately 93% of physicians who currently treat Medicare patients accept assignment, the hypothesis projected by our critics of steeply escalating prices appears unfounded.

As another element of savings, AMA's proposal greatly reduces waste and unnecessary administrative costs. An undistorted market will wither nonessential costs, while maintaining those elements that truly contribute to greater value in caregiving. In addition, the AMA advocates institutionalizing modernized Medicare administrative practices to include computerization of patient records and claims systems (embracing confidentiality and security measures for individuals' health information), a public-private partnership to explore telemedicine's promise, and changing payment policies to encourage preventive care and care provided in subacute or home settings.

## **BENEFICIARY CHOICES**

The heart of AMA's proposal would provide the elderly and disabled with several different options for Medicare. Each Medicare beneficiary would have an expanded set of choices that range from remaining in the restructured traditional Medicare program, to selecting from various competing health plans (including managed care options), to investing in a Medical Savings Account (MSA) coupled with a catastrophic plan. In general, Medicare patients would have enhanced opportunities to make prudent use of medical care resources and to be personally rewarded for those decisions.

How might people actually take advantage of greater personal responsibility under a transformed Medicare? One patient, for example, upon enrolling in the Medicare program, may decide to stay in "traditional" Medicare. Her spouse, however, may want to take advantage of one of the many managed care plans offered under a new "Medichoice" -- a plan very similar to the Federal Employee Health Benefit Plan (FEHBP) he had enjoyed when he was a postal worker. Their neighbor may decide to take advantage of the MSA option with a high deductible catastrophic policy offered under Medichoice. Each beneficiary could personally tailor the program to fit his or her individual circumstances and, in the vast majority of cases, each Medicare beneficiary will save money or spend the same amount as under the current system.

- I. A beneficiary electing to remain in the modified "traditional" Medicare:
  - would only have one form of cost sharing to replace the current multiple deductibles and coinsurance -- once they met a preset yearly deductible, all costs for covered services would be paid by Medicare, and beneficiaries would get a refund if they did not use their deductible amount;

- would have no need to purchase medigap insurance for deductibles and coinsurance of covered services and no need to fill out yet more forms; and
- would be able to **compare value** in choosing a physician using, in part, a published "conversion factor," and either pay the difference when the physician charges exceed the government payment or keep the savings when the government payment exceeds the physician charges.

This modified form of beneficiary cost-sharing will serve to reduce, on average, the individual's out-of-pocket costs, reward individuals for being prudent consumers of routine medical services, and reduce both patient and provider paperwork and other administrative complications of dealing with Medigap supplemental insurers.

II. Patients choosing "**Medichoice**" would have access to a wide range of plans similar to those offered by the Federal Employees Health Benefit Plan (FEHBP). Each person would receive:

- advance notice of the government's contribution (to be actuarially determined) toward the cost of Medichoice plans;
- information and rates on plans in the individual's area to assist "value comparison"; and
- a Medichoice election and enrollment form (available on attaining Medicare eligibility and on an annualized basis).

Patients would either pay the difference when the plan costs exceed the government contribution or keep the savings when the government contribution exceeds the plan costs.

III. Each Medicare-eligible individual would also have the option, in lieu of comprehensive plans (such as traditional Medicare or Medichoice), to establish a "Medical Savings Account" coupled with a catastrophic policy. Our MSA/catastrophic plan would:

- be funded by the government's annual contribution amount;
- consist of a fund from which the beneficiary would pay deductible medical expenses and a high deductible catastrophic medical expense insurance;
- allow unspent balances to accumulate in the fund; and
- provide for distribution from the MSA fund (exempt from federal and state income tax) for medical expenses, including health insurance premiums and long-term care expenses.

The MSA option would undoubtedly prove attractive to many beneficiaries because they could provide funds for purchase of items and services formerly not covered by Medicare, such as prescription drugs or extended long-term care.

In the AMA proposal, we specifically take into account those in our society who are most dependent financially on the Medicare program. Those whose incomes are at or below the poverty level would be exempt from any Medicare cost-sharing. Those with incomes between the poverty level and 150% of that level would face some cost sharing, adjusted on a sliding scale based on income.

Medicare must be transformed into a defined contribution program to tighten the program's original open-ended entitlement that has contributed so significantly to Medicare's fiscal instability. To serve beneficiaries optimally under such budgetary

constraints, however, the program must provide a wide variety of choices to allow for the full spectrum of needs and financial means within the beneficiary population.

The newly empowered Medicare beneficiary should not be restricted in choice of plans or providers. We must correct the current competitive disadvantage of physician-sponsored health plans. Physicians are positioned to ultimately balance the cost and quality equation better than any others in the marketplace, with the potential to save substantial amounts which today go to the administration and institutional investors of giant corporate plans. A simple program to help stimulate physician plans much as was done for HMOs in the 1970s is a necessary direction to pursue.

#### **QUALITY AND HEALTH PLAN STANDARDS**

As Medicare becomes a part of a meaningful way for patients to make choices in the private marketplace, costly and complicated government regulations can be reduced and the private sector can exercise its self-regulatory expertise. We are proposing an unprecedented "**Partnership for Health Care Value**" organization that focuses private sector efforts to promote standards of quality and rules of fair competition that protect the patient-physician relationship. The Partnership will also coordinate and expand current fragmented efforts to find, report and eliminate fraud and abuse. A dramatic, yet simple, way to materially decrease fraud is to share responsibility for its detection with organized medicine. According to the FBI, physicians are the least likely group to engage in fraud, yet the most useful in assisting in its prosecution.

The Partnership would also serve to educate physicians, providers and patients about reducing care of marginal value and increasing preventive care. It would build on current efforts in this arena, such as the soon-to-be-released booklet on health care advanced directives, jointly produced by the AMA, the American Bar Association and the American Association of Retired Persons. The Partnership would expand